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Human Resources: Glossary of Medical Plan Terms

Allowed Charge – This is the maximum amount on which payment is based for covered healthcare services. Also referred to as an "eligible expense," a "payment allowance," or a "negotiated rate."

Co-Insurance – The amount that a member is obligated to pay for covered medical services after satisfying any co-payment or deductible required by the health insurance plan. Co-insurance is typically expressed as a percentage of the charge or allowable charge for a service rendered by a healthcare provider. For example, if the health insurance company covers 80% of the allowable charge for a specific service, the member may be required to cover the remaining 20% as co-insurance.

Coordination of Benefits – The health insurance company will coordinate payment of covered services with hospital, medical, dental, health, or other plans under which a member is covered. The health insurance company will do this to make sure the cost of the member's healthcare services are not paid more than once. Other plans include personal injury insurance; automobile insurance, including medical payments coverage; homeowner's insurance; and other plans that cover hospital or medical expenses.

Co-payment – A specific charge that the health insurance may require the member to pay for a specific medical service or supply, also referred to as "co-pay." For example, the health insurance plan may require a $15 co-payment for an office visit or prescription drug, after which the insurance company often pays the remainder of the charges.

Deductible – A specific dollar amount that the health insurance company may require that members pay out-of-pocket each year before their health insurance plan begins to make payments for claims.

Explanation of Benefits ("EOB") – Also referred to as a "Claims Summary." A statement sent from the health insurance company to a member listing services that were billed by a healthcare provider, how those charges were processed, and the total amount of patient responsibility for the claim.

Health Care Flexible Spending Account ("Health FSA") - A benefit offered to an employee by an employer which allows a fixed amount of pre-tax wages to be set aside to pay for qualified medical expenses. The amount set aside must be determined annually or at hire. Any unused dollars in the account at the end of the year are forfeited. These are strict rules governed by the IRS.

High Deductible Health Plan ("HDHP") - A type of health insurance plan that has a higher annual deductible than a typical health plan, a maximum limit on the sum of the annual deductible and out-of-pocket medical expenses that you must pay for covered expenses. Out-of-pocket expenses include co-payments and other amounts, but do not include premiums.

Health Care Provider – A doctor, hospital, healthcare professional, or healthcare facility.

Health Insurance Portability and Accountability Act of 1996 ("HIPAA") - Title I of HIPAA provides the ability to transfer and continue health insurance coverage of American workers and their families when they change or lose their jobs. Title II of HIPAA requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. It also addresses the security and privacy of health data by improving the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the U.S. health care system.

Health Maintenance Organization ("HMO") - HMO plans offer a wide range of healthcare services through a network of providers that contract exclusively with the HMO, or who agree to provide services to members at a pre-negotiated rate. Under an HMO plan, a member must choose a Primary Care Physician (PCP) who will serve as the member's primary caretaker and make referrals to specialists as needed. Healthcare services obtained outside of the HMO network are typically not covered, though there may be exceptions in the case of an emergency.

Health Reimbursement Account ("HRA") - An HRA is an employer-sponsored plan that can be used to reimburse a portion of eligible family members' out-of-pocket medical expenses, such as deductibles, coinsurance and pharmacy expenses. It is not an insurance program, but a financial reimbursement plan funded entirely by the employer. The employer designates a specific dollar amount to credit to the account and determines what expenses the HRA can be used to pay for.

Health Savings Account ("HSA") – An HSA is a tax advantaged medical savings account available to employees who are covered by a High Deductible Plan (HDHP). It is a savings account with pre-tax contributions to be used to pay for qualified medical expenses. Funds deposited to the HSA are not subject to federal income tax. HSA funds rollover and accumulate year to year, and may be invested at the discretion of the employee owning the account. Interest or investment returns accrue tax-free. An HSA is owned by the employee and used to pay qualified medical expenses at any time without federal tax liability or penalty. Penalties may apply when funds are withdrawn to pay for anything other than qualifying medical expenses. Both employees and employers can contribute to an employee's HSA and the maximum contribution is limited every year. For 2013, if an employee has self-only HDHP coverage, contributions into an HSA cannot exceed $3,250. If an employee has family coverage, contributions cannot exceed $6,450. For 2014, the limits will increase to $3,300 and $6,550, respectively.

Inpatient – A patient who is a registered bed patient in a hospital or other covered healthcare facility and the health insurance company

has determined that inpatient care is medically necessary.

Loss-Ratio – The ratio of the annual claims paid by an insurance company to the premiums received. The medical plan carrier sets an expected loss ratio for each medical plan. For a plan to run efficiently, the carrier must receive enough in premiums to cover the claims paid under the plan, plus additional leftover to cover their administrative overhead expenses. When claims exceed the premiums paid, this is referred to as a "negative loss ratio."

Member – Anyone covered under a health insurance plan, including the subscriber (enrollee) and their covered dependents.

Network – Providers of medical care who have a contractual relationship with a health insurance company. This contractual relationship may establish standards of care, clinical protocols and allowable charges for specific services.

Out-of-Pocket Maximum – An annual limitation on the total out-of-pocket expenses members are responsible for under a health insurance plan in a calendar year. This limit does not apply to premiums, co-payments for office visits and Rx prescriptions, balance-billed charges from out-of-network health care providers, or services that are not covered by the plan.

Outpatient – A patient who is not a registered bed patient in a hospital or other health care facility. For example, a patient who is at a health center, at a health care provider's office, at a surgical day care unit, or at an ambulatory surgical facility is considered an outpatient.

Preferred Provider Organization ("PPO") - Medical care is obtained from doctors or hospitals on the insurance company's list of preferred providers. It allows the member the freedom to direct their own health care within a list of preferred providers.

Premium – The total amount paid to the insurance company for health insurance coverage. This is typically a monthly charge. Premiums are typically a shared cost between the employer and employee.

Preventive Health Services – Covered services that are performed to prevent diseases (or injuries) rather than to diagnose or treat a symptom or complaint, or to treat or cure a disease after it is present.

Primary Care Physician (or) Primary Care Provider ("PCP") - A primary care physician serves as a person's main healthcare provider. The PCP is the first point of contact for healthcare needs and may refer a person to specialists for additional services.

Referral – The process through which a member under a managed care health insurance plan is authorized by his/her primary care physician to see a specialist for the diagnosis or treatment of a specific condition.

Subscriber – The primary person who enrolls in the medical plan with the employer. Like the covered family members, the subscriber is also considered a 'member' of the plan.

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