Glossary of Insurance Terms

Balance Billing – A member may be billed the difference between what the insurance carrier covers and the fee the doctor or hospital normally charges.

Claim – Information submitted by a provider or covered person for reimbursement for services or materials.

COBRA – This law requires employers (with more than 20 total employees) to offer continued benefits coverage to employees who have had their benefits terminated.

Coinsurance (Annual) – The share of costs in a given plan between a member and the insurance company after the deductible has been met. It is expressed in percentages, for example 80% coinsurance means the insurance carrier will pay 80% of remaining costs and the member will pay 20% of costs until the out-of-pocket maximum has been met.

Combined (aggregate) Deductible – Occurs when there is a family on a plan. The entire family has a single, family deductible that must be met before anyone is covered at the coinsurance level. One person can meet the entire family deductible.

Community Rates – Applies to some group plans. Each covered person (regardless whether employee, spouse or child), is charged an individual premium based on age.

Composite Rates – Applies to some group plans. Employees pay the same amount depending on tier (ie. EE, EE+CH, EE+SP or FAM). Age or gender is not considered.

Deductible (Annual) – The amount the member must pay before the Plan begins to pay benefits.

Doctor Copayment – A fixed amount a member pays for a covered office visit, which can vary by plan design. For example, $15 for a primary care doctor office visit, or $30 for a specialist doctor office visit.

Effective Date of Coverage – The date that coverage begins, assuming premium has been paid. This date can also represent the date a change in coverage took effect.

Embedded Deductible – Occurs when there is a family on a plan. Creates two or three individual deductibles which comprise the total family deductible; two if there are two people on the plan, three if there are three or more people on the plan. If one family member has claims and satisfies their individual deductible, they will be covered at the coinsurance level, even if no other family member has claims. The family deductible must be satisfied by more than one family member.

Exclusions – Specific medical conditions or circumstances that are not covered under a plan.

Formulary – A listing of preferred drugs selected by a panel of physicians and pharmacists. A drug on the plan's Formulary benefits members as it gives them access to quality medications at a lower copayment or coinsurance rate. A member may use a drug not listed on the Formulary; however, it may require prior authorization and a higher copayment and/or coinsurance may apply.

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Grace period – A specified period following the date a premium payment is due.

Group Sponsored Plan – An ancillary plan offered by the employer in which the employer contributes a defined portion and employees can elect and pay the remainder of the premium.

Health Savings Account (HSA) – A medical savings account that provides a tax-free way to save, budget for, and pay qualified medical expenses. Requires enrollment in an eligible High Deductible Health Plan to be paired with HSA.

In-Network Provider – A physician, hospital or other health care provider that joins a managed care plan and provides services based on negotiated fees. Generally, using an in-network provider will save the member money in the form of copayments, lower deductibles and a higher reimbursement level.

Medically Necessary – Services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms that meet accepted standards of medicine.

Medicare/Group Primary – Applicable to group insurance. Fewer than 20 total employees, Medicare is primary. More than 20 total employees, group is primary.

Network – The providers and facilities contracted with to render health care to members. Members receiving in-network care generally obtain a higher level of benefits.

Out-of-network Provider – A provider that does not participate in the plan and therefore charges a non-discounted fee. Payments for out-of-network services are based on the plan and maximum allowable charges (MAC).

Out-of-pocket Maximum (Annual) – The most a member will pay in coinsurance during a benefit plan year. After reaching the out-of-pocket maximum, the medical plan pays 100% of eligible expenses for the remainder of the benefit plan year.

Per-Occurrence Deductible (POD) – Applies to Blue Cross Blue Shield ACA-Compliant plans. Applicable to certain benefits (emergency room, inpatient stay, outpatient surgery). The total claim is first subject to POD; the remaining amount will then be subject to the deductible and coinsurance. This charge is assessed for each occurrence until the plan OOPM is met.

Prescription Copayment – A fixed amount a member pays for a covered drug, which can vary by plan design. For example, $15/$30/$50 (Generic/Brand/Non-Formulary).

Preventative Services – Routine health care that includes screenings, check-ups to prevent illnesses, disease, or other health problems.

Referral – A written okay from the primary care physician to see a specialist or to receive certain services. Applies mostly to HMO plans.

SBC – Summary of Benefits and Coverage. A standardized plan summary mandated by The Affordable Care Act so as to be consistent across all carriers and plans. Required to be distributed to all plan enrollees.

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State Continuation – This law requires employers (with fewer than 20 total employees) to offer continued benefits coverage to employees who have had their benefits terminated.

Voluntary Plan – An ancillary plan offered by the employer in which the employer does not contribute, and that employees can elect and pay the entire premium.

Waiting period – Applicable to group insurance. The time before a full-time employee has to wait before he or she is eligible for coverage. Maximum 90 days or sooner at the option of the group.

Waivers – Applies to group insurance. Any eligible employee who chooses not to take the group's coverage. Eligible waivers include credible coverage through spousal coverage, Medicaid/Medicare, Individual policy. Ineligible waivers include an employee who chooses not to take the coverage because of the cost and doesn't have other credible coverage.