

## HEALTH INSURANCE TERMS

A **copayment** is a specified dollar amount that must be paid for covered health care services at the time care is received. The health insurer will pay the remainder of the amount allowed. Information on copayments is usually printed on the front of a member's health insurance card.

A **formulary** is a list of both brand-name and generic prescription drugs that are covered by a health plan. The formulary is determined with the assistance of a designated committee of physicians and pharmacists. The formulary may contain quantity limits or requirement for prior authorization before a drug is covered under the plan.

**Coinsurance** is a method of cost-sharing in a health insurance policy that requires a member to pay a stated percentage (for example 20 percent) of eligible medical expenses. The remaining percentage is the responsibility of the health insurance plan. Providers may request this coinsurance payment at the time of service.

A **deductible** is the initial amount of expense that a member is responsible for each benefit period before benefits are paid by the health insurer. Typical deductibles for traditional products are \$250, \$500 and \$1,000, and deductibles are reset after every benefit period (usually a year).

**Out-of-pocket maximum** is a specified dollar amount that is the most that a member will pay in coinsurance (some plans may also include deductibles) for covered services in the course of a benefit period.

A **premium** is the fee paid to the insurance company to purchase a health insurance plan. This can be paid on a monthly, quarterly or annual basis by an employer, an employee or an individual.

A **non-covered service** is a service that is specifically excluded from coverage in a health insurance plan, or exceeds any benefit maximums. Read your individual benefit description document for a full list of non-covered services or exclusions, which often include those considered experimental, investigational or convenience items.

A health insurer prepares an **Explanation of Benefits (EOB)** form for its members after a claim is adjudicated. The EOB is not a bill. It lists the services that were submitted and the results of the adjudication process for each service. Most times, members can opt to receive EOBs through the mail or electronically at the health insurer's Web site. Highmark offers both of these options.

A **generic drug** has the same active ingredients as a brand-name drug and is available when a brand-name drug's patent has expired. Generic drugs are often less expensive than their brand-name equivalent.

Typically, an **in-network provider** (such as a doctor, hospital or laboratory) has signed an agreement with a health insurer to provide services to that insurer's members at a discounted rate. Out-of-network providers have not signed an agreement with the insurer. When you use providers that are not in-network, you may have to pay significantly more for your health care service.

A **PPO (Preferred Provider Organization) plan** is a health insurance plan that allows members who seek care from an in-network provider to pay lower out-of-pocket costs. Members in a PPO can also seek care from out-of-network providers, but usually pay a higher portion of the cost of care.

An **HMO (Health Maintenance Organization)** is a health insurance plan that allows you to receive care through a network of participating providers. Generally, you select a primary care physician who is responsible for providing certain services such as routine exams and immunizations and also will help you in coordinating other health care services as needed. With the exception of emergency care, most services are not covered when received from providers that do not participate in the network.