HEALTH INSURANCE TERMS

Benefit Year
The 12-month period of benefits coverage under a health plan

Plan Year
The 12-month period of benefits coverage, under a group plan.

Policy Year
The 12-month period of benefits coverage, under an individual plan.

Deductible
The amount the patient pays for covered health care services before the insurance plan starts to pay their portion. After the deductible is met, the patient then usually pays a portion of covered services in the form of copays or coinsurance (see below). There may be separate deductibles for services like prescription drugs. Plans with lower premiums typically have higher deductibles.
Example: $2000 deductible - pt pays the first $2000 of covered services themselves.

Copay
A fixed amount a patient pays for a specific covered benefit *after* the deductible has been met, or sometimes in lieu of a deductible. Copays can vary for different services. Plans with lower premiums typically have higher copays.
Example: $3000 deductible has been met, patient will now pay $20 for PCP visit (instead of $80 that is allowed), $35 for specialist visit (instead of $160 that is allowed).

Coinsurance
A percentage of the plan's "allowed amount" (see below) that the patient pays *after* they have met the deductible. Plans with lower premiums typically have higher coinsurance.
Example: $3000 deductible has been met; patient will now pay 20% of covered services until their out-of-pocket maximum (OOP – see below) has been met.

Out-of-pocket maximum (OOP max)
This is the most a patient has to pay for covered health care services in a plan year. After the patient meets their OOP max, the health plan pays 100% of the cost of covered services. This does not include the cost of the monthly premiums
Example: $3000 deductible was met; patient paid an additional $2000 in copays or coinsurance, so they have met their $5000 out-of-pocket maximum

Stop-loss
Very similar to OOP max – when a patient has paid their deductible and has also met the maximum out-of-pocket for the coinsurance.

Allowed amount
Maximum payment a health plan will allow for a given covered service. If the provider charges more than the allowed amount, the patient may be responsible for the difference. Allowed amount may also be termed "negotiated rate" or "eligible expense".

Spend Down
This is a Medicaid term. Some people who apply for Medicaid do not qualify because they have too much income – this is termed "excess income". Some of these people may qualify for this spend down benefit if they spend this "excess income" on qualified medical bills.
Example: Patient is denied Medicaid because monthly income is $40 over the limit for eligibility; if this patient spends $40 on qualified medical bills, the rest of the medical bills she/he incur will be paid by Medicaid. The spend down is $40 in this case. Spend down eligibility is determined on a monthly basis, based on the amount of medical bills incurred by the patient and their "excess income".

Claim
The request for payment that a patient or health care provider submits to a patient's health insurer.

Appeal
The process of requesting a patient's health insurer to review a decision (denial) or grievance again. Often, additional records or information are requested by the insurer in order to evaluate the request.

Medically necessary
Services or supplies that are needed to diagnose, or treat a condition/its symptoms that meet generally accepted standards of medicine.

Preauthorization
A decision by a patient's health plan that a service/treatment (or medication, equipment) is medically necessary. This is not a guarantee of payment by the health plan and is also called prior authorization, prior approval, or precertification.

Referral
Written (or online) order from a patient's primary care physician to see a specialist or to obtain/receive certain medical services (such as cardiac rehab). Many HMOs require this.

In-network provider
A provider (e.g., physician) contracted with the health insurance company to provide services to plan members for specific pre-negotiated rates

Out-of-network provider
A provider (e.g., physician) is one not contracted with the health insurance plan.

Out-of-State
If a patient has insurance from a different state, their plan may state "OOS" (e.g. BCBS OOS). Insurance information and benefits can still be obtained by contacting the company provider line (typically published on the back of the insurance card). In-network and out-of-network benefits and preauthorization requirements may be different, so this needs to be verified during the call to the plan.

Health Maintenance Organization (HMO)
Health care under an HMO plan is covered only if you see a provider within that HMO's network. The network is comprised of providers that have agreed to lower rates for plan members. Additional restrictions for coverage exist, such as allowing only a certain number of visits, tests or treatments and the need for a referral or preauthorization.

Preferred Provider Organization (PPO)
PPO plans provide more flexibility when choosing a doctor or hospital. They also feature a network of providers, but there are fewer restrictions on seeing non-network providers (but this may result in higher copays/coinsurance).

Sources: www.healthcare.gov , www.healthinsurance.org and health care specialists that perform insurance verifications from Beaumont Health