Ascension
Personalized Care

Healthcare terms to know

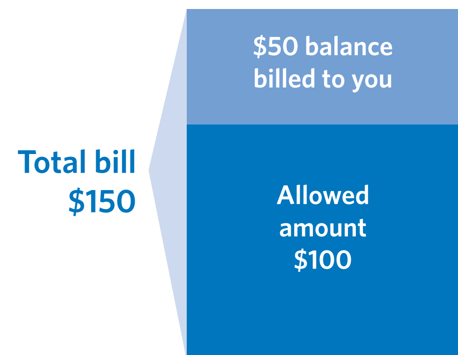
We know health care terminology can be confusing. To help you better understand, we have created a glossary of common terms and examples of how they are used.

Aggregate deductible plan

A type of health care plan in which the entire family deductible must be met before any member has access to after-deductible benefits, even if a member had satisfied their individual deductible.

Allowed amount

The maximum amount your plan will pay for a covered service. In-network doctors have agreed to bill for the allowed amount. If an out-of-network doctor charges an amount greater than the allowed amount, you may be responsible for the balance. This is called balance billing.



Balance billing

If you see an out-of-network doctor, they may bill for an amount higher than the allowed amount. Your plan may not cover the difference between the billed amount and the allowed amount, and this balance becomes your responsibility. For example, if you see an out-of-network doctor for a $150 office call, but your plan's allowed amount is only $100, the clinician may bill you for the remaining balance.

Benefit period

The period of time (usually a year) when services are covered under your plan. During the benefit period, payments toward deductibles and out-of-pocket maximums are accumulated. After a benefit period ends, these accumulated payments are set to zero and a new benefit period begins, even if the deductible and out-of-pocket maximums are not reached.

Care management

A program designed for members that provides assistance, education, and support to better manage their care.

Change event

A life event such as marriage, the birth of a child, or loss of other health insurance. These events allow the member to make changes to their plan outside of the open enrollment period.

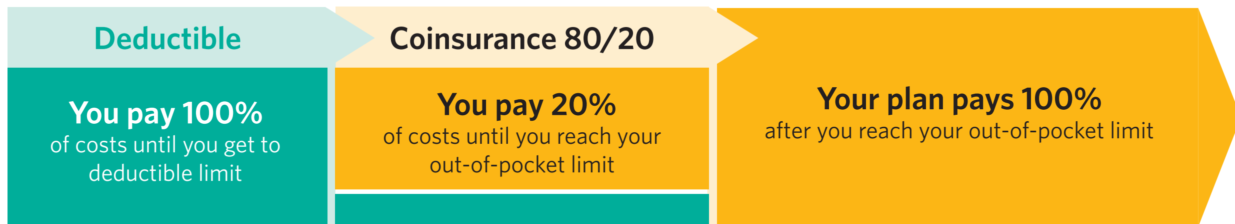
Claim

A request for payment for health services you receive. Claims are submitted by you or your health care doctor and reviewed by your insurer.

Clinician
A doctor, hospital, clinic, or other qualified health care professional who provides medical services to the member.

Coinsurance
Coinsurance is the amount you pay after you reach your deductible. Your health insurance plan will pay a portion of the medical bill and you will be responsible for paying the rest. For example, if you have a $1000 deductible and a 20% coinsurance responsibility, and you received a service at a cost of $2000, you would be responsible for paying the full deductible ($1000) and 20% of the remaining balance ($200) for a total of $1200, while the plan pays the remaining $800.

Coinsurance: who pays what and when



Condition
An injury, ailment, disease, or disorder requiring medical care.

Copayment (or copay)
A copay is a flat fee that you pay when you visit a doctor. It is a set amount of money you pay for a covered service.

Cost share (or member share)
Cost sharing refers to a number of methods allowing the member and the insurer to share the cost of covered services, requiring the member to pay out-of-pocket costs. Examples of cost sharing include deductibles, copays, and coinsurance.

Covered service
Healthcare services that are covered by a specific benefit provision of the health insurance plan, and that are not excluded under the plan. They are determined to be medically necessary per the plan's medical policies and paid for by the plan.

Deductible
A deductible is the amount you pay for healthcare services before your health insurance begins to pay.

Dependent
A child, spouse, or other individual who relies on the subscriber for support and is covered by their health plan.

Durable medical equipment (DME)
Supplies or equipment ordered by a medical doctor to assist with the treatment of an injury or medical condition. Examples of DME include wheelchairs, oxygen tanks, insulin pumps, and crutches.

Emergency medical condition

Any condition, injury, or illness in which lack of immediate medical attention could result in serious damage to your body, health, or well-being.

Exclusions (or excluded services)

Any service, procedure, or supply not covered by your health plan.

Exclusive Provider Organization (EPO)

Often referred to as a narrow network. It is similar to an HMO (Health Maintenance Organization) in that it has a specific list or an exclusive network of doctors and doesn't cover most out-of-network care. But an EPO allows the patient to visit any doctor in their network without a referral from their PCP (Primary Care Provider).

Evidence of coverage

Evidence of coverage is a document that provides details about what your health insurance plan covers, how much you will pay, and additional plan details.

Explanation of benefits (EOB)

An explanation of benefits is a statement that describes the costs of medical care received. It explains what portion of a claim (a request for payment submitted by your healthcare doctor for covered items or services) was paid to the healthcare doctor and what you will be responsible for paying.

Formulary (or drug formulary)

A list of prescription drugs, both brand name and generic, that are determined to be the most cost-effective options for treatment of a medical condition. These drugs are chosen by your plan, and are sometimes divided into tiers, with each tier representing a different cost-share level.

Health benefits subsidy

A discount on the amount a member must pay to participate in a health care plan. This discount can reduce premiums, deductibles, copays, and other cost-share amounts, and is based on financial need. An application must be submitted by the member to be considered for this subsidy.

Health system

A system of institutions, medical professionals, and resources working together to provide and maintain high-level health care.

In-network

Referring to any doctor, service, or procedure that is contracted with the network associated with the member's plan. In-network services are covered at a lower rate than out-of-network services. In some plans, there is no out-of-network coverage at all.

Medically necessary

Health care services or supplies necessary to diagnose or treat an illness, injury, condition, disease, or associated symptoms. These services or supplies must meet the accepted standards of medicine to be deemed medically necessary.

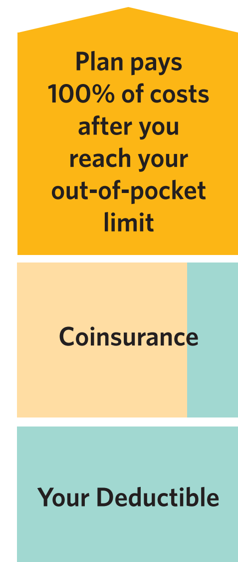
Member
A member is a covered person enrolled under the health insurance plan.

Network
The doctors, hospitals, and other health services contracted with a health insurer to meet the medical needs of its members.

Network clinician
A network clinician is a healthcare clinician (doctor, nurse practitioner, clinical nurse specialist, or physician assistant) that is contracted with your health insurance plan to provide a better rate.

Open enrollment period (OEP)
An open enrollment period is a specific time each year you can sign up for health insurance or change your coverage or plan. The federal exchange is open November 1 - December 15 each year.

Out-of-network
Referring to any doctor, service, or procedure that is NOT contracted with the network associated with the member's plan. Out-of-network services are covered at a higher rate than in-network services. In some plans, there is no out-of-network coverage at all.



Out-of-pocket
Any costs for covered services that are the responsibility of the member. These include deductibles, coinsurance, and copays. The health plan sets an out-of-pocket-limit for each benefit year, at which point the plan begins to pay 100% of the allowed amount for covered services.

Out-of-pocket-limit (or out-of-pocket maximum)
An out-of-pocket maximum is the most amount of money you will have to pay during the plan year. Once this out-of-pocket maximum is met, the health insurance plan will cover all costs at 100%.

Plan
A health insurance plan refers to Ascension Personalized Care.

Premium
A premium is the amount you pay monthly to have health insurance coverage.

Preventive care (or preventive services)
Services provided to healthy individuals with the intent of preventing illness and maintaining health. Preventive services include well baby exams, physicals, immunizations, and certain cancer screenings.

Prior authorization
A prior authorization is an approval that a member must receive from their health plan before receiving certain treatment, medications, or services.

Specialist

A doctor who specializes in treating specific diseases, parts of the body, or age groups.

Specialty drug (or specialty medication)

High-cost prescription drugs used to treat complex or chronic conditions such as multiple sclerosis, hepatitis C, and rheumatoid arthritis. Specialty drugs fall into a higher drug tier and may require use of a specialty pharmacy.

Schedule of benefits

A schedule of benefits is a list of services covered under the health plan and includes information on copays, deductibles, and any other fees.

Summary of Benefits and Coverage (SBC)

A summary of benefits and coverage (SBC) is a document that shows deductible and copay information as well as everything that is covered under the health insurance plan.

Special enrollment period

A special enrollment period is a set time when you can enroll in health insurance if you have had a certain life event. This can include losing health coverage, moving, getting married, having a baby, or adopting a child.

Third party administrator (TPA)

An organization that processes claims and performs certain administrative duties related to a benefit plan

Urgent care center (or urgent care facility)

A facility providing treatment for unexpected illnesses or conditions requiring medical attention, yet not considered severe enough to require use of a hospital emergency visit. Examples of urgent care medical conditions include fever, sore throat, and earache.

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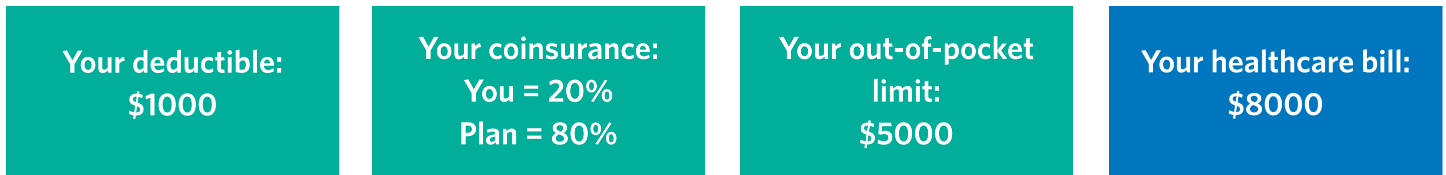
Coinsurance: understanding how it works

Coinsurance can seem confusing at first, so let's break it down to help you better understand how it works. For our example, we'll look at a health care bill totaling $8000. You have a deductible of $1000 and an out-of-pocket limit of $5000.



If you haven't met your deductible, you will first pay that amount in full. After that, you will pay 20% of the remaining balance of the charges – in this example, the remaining balance is $7000.

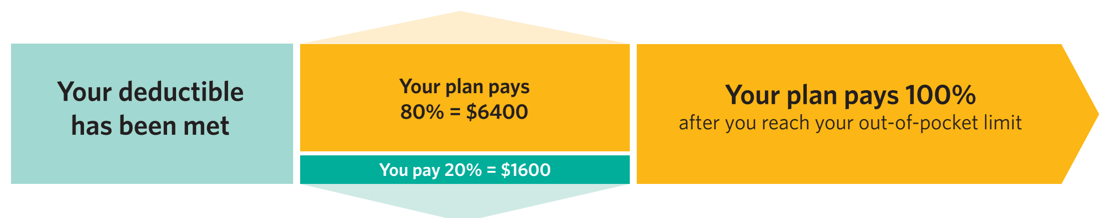
Deductible = $1000
20% of $7000 = $1400

You pay $2400
Plan pays $5600

Let's say you receive the services and are billed $8000 after you've met your deductible. Now you only pay 20% of the charges until you reach your out-of-pocket limit.

20% of $8000
80% of $8000

You pay $1600
Plan pays $6400



If you receive the services after your out-of-pocket limit is met, your plan then covers 100% of the charges – in this example, the full $8000 charge.

You pay $0
Plan pays $8000