HOW HEALTH CARE WORKS

Health Insurance 101

WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

This guide defines many commonly used terms, but it isn't a full list. It is intended to be educational and may differ from the terms and definitions in your own plan or health insurance policy. See page 4 for an example showing how deductibles, coinsurance, and out-of-pocket limits work together in a real-life situation.

A

Allowed Amount
The maximum payment the plan will pay for a covered health care service. Health care providers are permitted to charge other than this amount. A network provider agrees to accept the allowed amount as payment in full.

Appeal
A request that the health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

B

Balance Billing
When a provider invoices the member for the difference between the actual charge amount and the allowed amount. Participating network providers are not able to balance bill their patients since they have agreed to accept the allowed amount as payment in full. Providers are able to bill for cost sharing amounts, which is separate from balance billing.

Benefit Manager
Any person or entity that provides services to or acts on behalf of a health carrier or employee benefits program.

C

Charge
The dollar amount a provider establishes for services rendered.

Claim
A request for a benefit (including reimbursement of a health care expense) made by the member or their health care provider to the health insurer for items or services the member believes are covered.

Coinsurance
The member's share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service.

Copayment
A fixed amount paid for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.

Cost Sharing
The share of costs for services a plan covers that the member must pay out of their own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance.

Cost-sharing Reductions
Discounts that reduce the amount paid for certain services covered by an individual plan bought through the Marketplace, if income is below a certain level or the member belongs to a federally recognized group.

D

Deductible
Amount owed during a coverage period (usually one year) for covered health care services before the plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan may also have separate deductibles that apply to specific services.

E

Emergency Medical Condition
An illness, injury, symptom or condition severe enough to risk serious danger to the member's health if they didn't get medical attention right away.

Emergency Medical Transportation
Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea.

Emergency Room Care / Emergency Services
Services to check for an emergency medical condition and treatment to keep an emergency medical condition from getting worse.

Excluded Services
Health care services that the plan doesn't cover.

F

Fee for Service
A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Formulary
A list of drugs the plan covers. A formulary may include the share of the cost for each drug. A plan may put drugs in different cost sharing levels or tiers.

Fully-insured Plan
A group health plan in which the employer or association purchases health insurance from a commercial insurer in order to provide coverage for its employees or association members.

H

Habilitation Services
Health care services that help a person keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, or other services.

Health Insurance
A contract that requires a health insurer to pay some or all of a member's health care costs in exchange for a premium. A health insurance contract may also be called a policy or plan.

Home Health Care
Health care services the member receives at home under a doctor's orders. May include services provided by nurses, social workers, or other licensed health professionals.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

I

In-network Coinsurance
The member's share (for example, 20%) of the allowed amount for covered health care services. The share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) the member pays for covered health care services to providers who contract with their health insurance or plan. In-network copayments usually are less than out-of-network copayments.

M

Marketplace
A marketplace for health insurance where individuals, families, and small businesses can learn about their plan options; compare plans based on costs, benefits, and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for a member's plan.

Medically Necessary
Describes health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

N

Network
The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with a health insurer or plan who has agreed to provide services to members of a plan. Members will pay less if they see a provider in the network. Also called "preferred provider" or "participating provider."

O

Out-of-network Coinsurance
The member's share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with the health insurance or plan. Out-of-network coinsurance usually costs more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) the member pays for covered health care services from providers who do not contract with their health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-preferred Provider)
A provider who doesn't have a contract with the plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. The policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Out-of-pocket Limit
The most the member could pay during a coverage period (usually one year) for their share of the costs of covered services. After meeting this limit the plan will usually pay 100% of the allowed amount. Some plans don't count all copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

P

Pharmacy Benefit Managers (PBMs)
Third-party administrators for prescription drug programs for health plans. Their roles include negotiating discounts and rebates with drug manufacturers, developing and maintaining drug formularies, developing and managing pharmacy networks, examining claims, and other functions.

Physician Services
Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

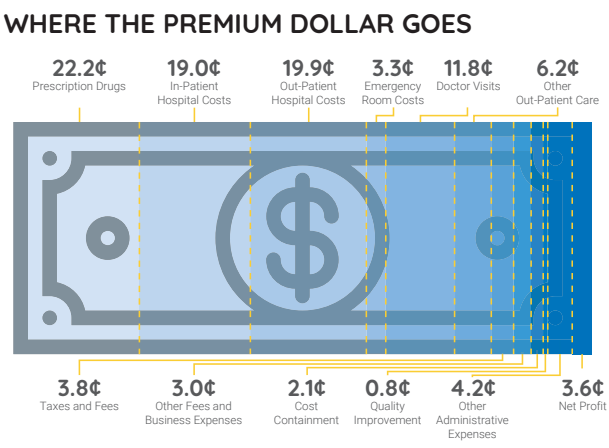
Plan
Health coverage issued to the member directly (individual plan) or through an employer, union, or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called health insurance plan, policy, health insurance policy, or health insurance.

Prior Authorization
A decision by the health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called preauthorization, prior approval, or precertification. The health insurance or plan may require prior authorization for certain services before the member receives them, except in an emergency.

Premium
The amount that must be paid for the health insurance or plan. Most often, the member or employer pays the premium monthly.

Premium Tax Credits
Financial help that lowers the member's taxes to help them pay for private health insurance, if the health insurance is purchased through the Marketplace and the member's income is below a certain level. Above the income thresholds, the individual's premium is limited to a percentage of income.

Prescription Drug Coverage
Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount paid in cost sharing will be different for each "tier" of covered prescription drugs.



Source: AHIP, *www.ahip.org/resources/where-does-your-health-care-dollar-go*
Data reflects averages nationally for the 2018-20 benefit years.

Preventive Care (Preventive Service)
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Provider
A health care professional, including an M.D., Doctor of Osteopathic Medicine, Physician Assistant, or Nurse Practitioner who provides or coordinates health care services for the member.

Provider
An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, or rehabilitation center.

R

Rehabilitation Services
Health care services that help a person keep, get back, or improve functioning lost or impaired through sickness, injury, or disability. These services may include physical and occupational therapy, speech-language pathology, or psychiatric rehabilitation.

S

Screening
Preventive care that includes tests or exams to detect the presence of something, usually performed when the member has no symptoms, signs, or prevailing medical history of a disease or condition.

Self-insured Plan
A health plan, also known as a self-funded plan, offered by an employer or association in which the employer or association takes on the risk involved with providing coverage, instead of purchasing coverage from an insurance company.

Skilled Nursing Care
Services performed or supervised by licensed nurses in the member's home or in a nursing home. Skilled nursing care is not the same as "skilled care services," which are services performed by therapists or technicians.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

U

Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How the MEMBER and the INSURER Share Costs

JANUARY 1

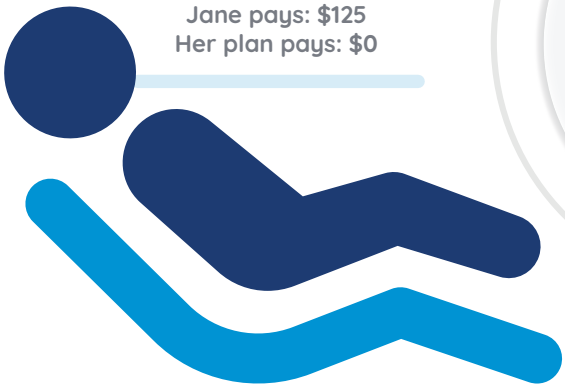
Beginning of coverage period

DECEMBER 31

End of coverage period

1

Jane hasn't reached her $1,500 deductible yet. Her plan doesn't pay any of the costs.
Office visit charge: $150
Network provider allowed amount: $125
Jane pays: $125
Her plan pays: $0



1

Jane pays 100% of allowed amount
Plan pays 0%

JANE'S DEDUCTIBLE

$1,500

2

Jane reaches her $1,500 deductible and coinsurance begins. Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible, so her plan pays some of the costs for her next visit.
Office visit charge: $150
Network provider allowed amount: $125
Jane pays: $25 (20%)
Her plan pays: $100 (80%)

2

Jane pays 20% of allowed amount
Plan pays 80%

JANE'S COINSURANCE

20%

3

Jane reaches her $5,000 out-of-pocket limit. Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit charge: $150
Network provider allowed amount: $125
Jane pays: $0
Her plan pays: $125

3

Jane pays 0% of allowed amount
Plan pays 100%

JANE'S OUT-OF-POCKET LIMIT

$5,000

Note: This is an illustration of how health insurance works. Plans differ.