Common health insurance terms.

When you're choosing a health plan that's offered by your employer, you'll run across terms and phrases that may be unfamiliar to you. Understanding these common health insurance terms can help as you decide on coverage for the coming year.

Coverage terms

What's covered under each plan varies. Here are some common terms to know about coverage:

Term:	Definition:
Diagnostic care	Care you receive to help diagnose symptoms or risk factors you already have.
Network	The health care providers (facilities, doctors, specialists and suppliers) your health insurer or plan has contracted with to provide health care services.
Out-of-network (OON)	The health care providers (facilities, doctors, specialists and suppliers) that are not contracted with your health insurer or plan to provide health care services.
Preauthorization	A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.
Preventive care	We also offer condition management programs to help members with chronic health issues—such as chronic kidney disease, diabetes and heart failure—enhance self-care, identify warning signs and access resources for assistance. This helps reduce the need for urgent or emergency services.
Primary care provider (PCP)	Routine health care, including screenings, check-ups and patient counseling to prevent or discover illness, disease or other health problems.
Referral	A written order from your primary care provider for you to see a specialist or get certain health care services.
Specialist	A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has special training in a specific area of health care.

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Cost terms

No matter which health insurance plan you choose, you and your plan will share costs of your care. When comparing plans, knowing these cost terms will help you understand what costs you're responsible for, and when.

Term:	Definition:
Coinsurance	The amount shared by you and your plan for health costs, calculated as a percentage. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.
Copayment	The fixed amount you pay each time you see a network provider.
Deductible	The amount of health costs you are responsible for before the plan starts sharing costs. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.
Flexible spending account (FSA)	A health care account that lets you put money aside, tax-free, to spend within the plan year to help pay for medical costs, child care, and other health services.
High-deductible health plan (HDHP)	High Deductible Health (HDHP) plans, a type of Consumer Directed Health Plan (CDHP) or Consumer Health Plan (CHP), are becoming increasingly popular for those who don't need to see the doctor very often. These plans may behave like an HMO or PPO plan, but have much higher deductibles to meet in exchange for lower monthly premiums.
Health reimbursement account (HRA)	A health care account that employers fund for covered workers or retired persons to pay for health care expenses.
Health savings account (HSA)	A bank account that lets you put money aside, tax-free, to save and pay for health care expenses. Any remaining money at the end of the plan year is yours to keep.
Out-of-pocket limit (OOPL)	The total amount of health costs you are responsible for before your plan pays 100% of covered health costs for the rest of the year.
Premium	The amount you pay for a health insurance plan that is deducted from your employee paychecks.

Prescription drug coverage terms

The plans you're considering may offer prescription drug coverage. Knowing these terms may help you understand how your medication coverage works.

Term:	Definition:
Drug tiers	A 3-to-4 level tiered system that determines how each plan covers different types of prescription drugs. Each tier is typically assigned a cost you will pay for drugs listed in that tier.

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Prescription drug list (PDL)	Every plan with a pharmacy benefit contains a Prescription Drug List (PDL), also known as a formulary. The PDL lists the plan-approved drugs that your insurance will help pay for as well as how cost sharing works in each tier of drugs.
Generic drugs (Tier 1)	FDA-approved prescription drugs not associated with a brand name.
Preferred brand name drugs (Tier 2)	FDA-approved brand name prescription drugs.
Non-preferred brand name drugs (Tier 3)	FDA-approved brand name prescription drugs.
Prior authorization	A requirement from your health plan that some medications have additional coverage requirements which require approval from the health plan before you receive the medication.