Glossary of Health Insurance Terms

Term	Plan Definition	Plain Meaning	You might see it used like this . . .
Benefit year	"Jan. 1-Dec. 31"	Each year, the Department of Retirement and Benefits (DRB) issues a new version of the health plan booklet. The plan applies from Jan.1-Dec. 31, unless DRB issues amendments.	Open enrollment is held annually and elections will apply to the following benefit year.
Brand name prescription drug	"A prescription drug with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by Aetna."	Prescription drugs are patented by the drug manufacturers who produce them. After a drug has been on the market for a period of time, the patent expires and new drug manufacturers can make generic versions of the drug. The generic versions are often much cheaper than the brand name, patented drugs.	Your minimum payment for a non-preferred brand-name prescription drug is $80. Your maximum payment is $150.
Claims Administrator	"A person, firm, or company which has agreed to provide technical or administrative services and advice in connection with the operation of all or a part of a benefit provided for under the plan, and perform such other functions, including processing and payment of claims, as may be delegated to it under such contract. The claims administrator may review claims and, if applicable, coordinate external reviews, as provided by the plan."	The State of Alaska has its own health plan. The plan is a written document that outlines health, dental, and vision benefits. DRB contracts with private companies to manage our plan. The current plan administrator for medical and prescription claims is Aetna. Delta Dental is the claims administrator for the dental plan; Vision Services Plan manages the vision plan and Payflex administers the health flexible spending accounts and COBRA.	"You may initiate a first level of appeal of the denial of a claim by a filing a written appeal with the claims administrator within 180 calendar days of the date the Explanation of Benefits or pre-service denial letter was issued[.]"
Coinsurance	"The percentage of covered expenses which the plan pays after application of any applicable deductible."	Employees and dependents are responsible for paying a percentage of costs for medical services. Depending on the employee's plan, the service, and the provider, employees can be responsible for paying anywhere between $0 and 50% of covered expenses.	Employees and dependents covered by the Consumer Choice Plan pay 50% of the cost of services from an out-of-network free-standing imaging center. OR Employees covered by the Economy Plan pay no coinsurance for preventative care

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			with a network provider. The plan pays 100%.
Copayment	"The specific dollar amount required to be paid by you or on your behalf by the plan."	Some services or prescriptions require you to pay a specific dollar amount, rather than a percentage of the total cost.	Under the vision plan, contact lenses from a network provider are covered 100% after payment of the $60 copayment. OR There is a $100 copayment for a non-preferred brand-name prescription drug for a 31-90 day supply from a network pharmacy.
Deductible	"The amount of covered expenses for which you are responsible each benefit year before any benefits are payable under the plan."	The specific dollar amount that you must pay before the plan will begin to pay for covered expenses. After you satisfy this amount, you must still pay coinsurance. Note: The plan will pay for preventative services before you satisfy your deductible.	From the 2018 plan, p. 27: "After you satisfy any applicable deductible, you will be responsible for any applicable coinsurance for covered expenses that you incur up to the applicable out-of-pocket limit."
Facility services	No plan definition.	Any treatment (other than emergency services) received at a hospital, rehabilitation facility, surgery center, or free-standing imaging center.	If receiving any of these types of services, you must use a preferred provider in Anchorage or a network provider outside of Anchorage, or face steep penalties.
Formulary	"A listing of prescription drugs (both generic prescription drugs and brand-name prescription drugs) established by the plan administrator. The formulary will tell you if a drug is covered and tell you what plan payment tier it is in. You can also see if there are alternatives that cost less. The list is subject to periodic review and modification. This list is outlined in the Preferred Drug Guide. The Preferred Drug Guide also includes an Exclusion List of drugs that are identified as excluded under the plan, subject to periodic review and modification."	A list of drugs covered by the plan, classified as generic (lowest cost/First Tier), preferred brand (a slightly higher cost/Second Tier), non-preferred brand (a higher cost/Third Tier), preferred specialty (lower cost for specialty drugs), and non-preferred specialty (higher cost for non-preferred specialty drugs). Found at: http://doa.alaska.gov/drb/benefits /materials/2018_aetnadrugguide.pdf	When getting a prescription, you might ask your doctor whether there are generic alternatives. There are some drugs that are not covered at all, and Aetna has a separate formulary for excluded drugs and alternatives that are covered. http://doa.alaska.gov/drb/benefits/ materials/2018_exclusiondruglist.pdf

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Generic prescription drug	"A prescription drug, whether identified by its chemical, proprietary, or nonproprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by Aetna."	You will pay the lowest amount for generic prescription drugs.	The plan will pay 80% of the cost of a 30-day supply of a generic prescription drug at a network pharmacy.
Hidden provider charges	No definition in plan.	Hidden provider charges are charges from providers that may have been a part of your treatment, but that may work for a different entity as the main provider and so may be billed separately. Although the primary provider may be a network provider, the hidden provider could be out-of-network.	When you receive imaging services from a network provider, that provider may contract with outside, out-of-network radiologists to read your images. You will pay a higher cost for these providers.
Medically necessary	Plan Section 3.5.1. Determined by Aetna's current Medical and Pharmacy Clinical Policy Bulletins (CPB): http://www.aetna.com/healthcare-professionals/policies-guidelines/clinical_policy_bulletins.html. When a service or supply is not addressed by a CPB, Aetna determines whether service "would be given to a patient for the purpose of evaluating, diagnosing, or treating an illness, an injury, a disease, or its symptoms by a physician or other health care provider, exercising prudent clinical judgment."	Some services will not be covered by the health plan because they may not be determined to be medically necessary. There are many factors that go into this determination. If you have a question about whether a service is medically necessary, consider asking a Healthcare Advocate.	"Not every service, supply or prescription drug that fits the definition of medical necessity is covered by the medical plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example, some benefits are limited to a certain number of days or visits to a dollar maximum."

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Negotiated charge	"The maximum charge that a network provider has agreed to make as to any service or supply for the purpose of benefits under the plan."	Aetna and network providers set standard rates for specific services. When you use a network provider, the amount they bill the plan will generally be lower than their standard price for the service because they follow the negotiated charge.	On an Explanation of Benefits, the negotiated charge will appear as the "member rate." If you are using a network provider, the member rate should be less than the amount billed. The member rate, or negotiated charge, is the amount Aetna will use to calculate your coinsurance.
Network pharmacy	"A pharmacy that has contracted with Aetna to furnish services or supplies for the plan." Can be found at: www.aetna.com/docfind	Network pharmacies will bill your insurance for its share of prescription cost sharing.	When you use an out-of-network pharmacy, you are responsible for paying the pharmacy directly for prescriptions and submitting a claim for reimbursement from the plan.
Network provider	"A health care provider or pharmacy that has contracted with a claims administrator to furnish services or supplies for the plan, but only if the provider is a network provider for the service or supply involved." www.aetna.com/docfind	You will see your lowest out-of-pocket cost for most services when you use a network provider. Your coinsurance and out-of-pocket maximum with both be lower and you will pay nothing for preventative services, which are covered at 100% at a network provider. And when you use a network provider you are not responsible for obtaining precertification.	Dental network providers are identified in Delta Dental's directory, which can be found online at www.deltadentalak.com.

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Out-of-pocket limit	"The maximum amount you are responsible to pay for benefits under the plan each benefit year, including deductible and coinsurance not paid by the plan. Premiums, charges over the recognized charge, precertification benefit reductions, and non-covered expenses do not accrue toward the out-of-pocket limit. A separate out-of-pocket limit applies with respect to the medical benefit portion and prescription benefit portion of the plan."	Your out-of-pocket limit is the amount you must pay, including your deductible and coinsurance, before your benefits will be covered at 100% under the plan.	When receiving services at an out-of-network facility, such as a hospital or free-standing imaging center, the out-of-pocket limit that otherwise applies under the medical plan will be doubled.
Precertification	"A process where the claims administrator is contacted before certain services are provided. It is not a guarantee that benefits will be payable."	You have to get prior approval to obtain certain services, including travel, preventative services at an out-of-network provider, and any service listed on page 32 of the plan (includes many things, but common services would include stays in a hospital or facility, dialysis visits, MRI of knee or spine, intensive outpatient treatment programs).	"You are responsible for obtaining the necessary precertification from Aetna prior to receiving services from an out-of-network provider. Your provider may pre-certify your treatment for you; however, you should verify with Aetna prior to the procedure that the provider has obtained precertification from Aetna."
Preferred Provider	The plan does not define "preferred provider," but does state, "The medical plan has a facility-only preferred provider agreement for facility services in the municipality of Anchorage. The preferred facilities in the municipality of Anchorage are Alaska Regional Hospital, and their affiliated surgery center Surgery Center of Anchorage."	In Anchorage, a preferred provider facility (hospital, surgery center, rehabilitative facility, or free-standing imaging center) differs from an out of network facility because the penalties for using a non-preferred provider facility are higher than the typical penalty for using an out-of-network provider. AND when selecting facility services outside of Anchorage, employees who use an out-of-network hospital, surgery center, or free-standing imaging center will suffer the same penalties applied to use of a non-preferred provider facility in Anchorage.	If you use a non-preferred provider, you will pay an additional 20% coinsurance, your out-of-pocket maximum will double, and the recognized charge will be reduced to the percentage of Medicare that most closely reflects the aggregate contracted rate at the preferred hospital or facility in the Municipality of Anchorage.

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Prevailing charge rate	"Rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health." https://www.fairhealthconsumer.org/	The prevailing charge rate is the "going rate" for certain services as reported in the FAIR Health database. When Aetna does not have a set rate for a service because a provider is out-of-network, the prevailing charge rate is used to determine what Aetna thinks is a reasonable rate for the service. Aetna does not always update FAIR Health data.	When determining the recognized charge, Aetna will pay the lesser of the provider's bill or the 90th percentile of the prevailing charge rate for the geographic area.
Recognized charge	"The negotiated charge contained in an agreement the claims administrator has with the provider either directly or through a third party. If there is no such agreement, the recognized charge is determined in accordance with the provisions of this section. An out-of-network provider has the right to bill the difference between the recognized charge and the actual charge. This difference will be the covered person's responsibility."	The recognized charge is the contract rate Aetna has with a network provider. For an out-of-network provider, the recognized charge is the amount Aetna determines to be a reasonable charge based on the following formulas: Medical services—lesser of provider's bill or 90th percentile of prevailing charge rate for geographic area; Facility expenses in Anc and outside of AK-out-of-network—lesser of provider's bill or 185% of Medicare rate for service; Free standing imaging center—50% of amount billed.	The recognized charge, is the amount Aetna will use to calculate your coinsurance.