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Health Care Benefits Glossary of Terms

Health care benefits provide preventive and protective medical, dental, vision, or prescription drug coverage to employees and their families. Most employer-provided plans cover the employee and the employee's dependents, including spouse and children.

- A -

Administrative services only (ASO). Under this type of plan, a third party disburses the employer's funds to pay claims and handle other administrative details.

Alternatives to Hospitalization: Alternatives are offered as a means of reducing costs.

- **Skilled nursing facilities (SNF).** A benefit that provides rehabilitation and convalescent services, as well as skilled nursing care, to patients who require less intensive treatment than that provided in a hospital.
- **Home health care.** These services provide skilled nursing and related care of patients in their own homes.
- **Hospice care.** These programs provide nursing care and psychological support for terminally ill patients and their families, either on an inpatient basis or in the patient's home.

- D -

Dental care: Dental care plans provide services or payments for restorative care and related dental services.

- **Preventive services.** Preventive services are routine exams, cleanings, and x-rays.
- **Major services.** Major services are dental surgery, endodontics (root canal therapy), periodontics (treatment for gum disease), crowns, and prosthetics (replacement of missing teeth with bridgework or dentures).
- **Orthodontia services.** These are services for the correction of malpositioned teeth.

- F -

Fee-for-service plans:

- **Traditional fee-for-service plan.** A plan that finances, but does not deliver, health care services; the plan allows participants the choice of any provider, without affecting reimbursement. Employers pay premiums to a private insurance carrier to provide a specific package of health benefits. Some employers may choose to self-fund a fee-for-service plan, in which case the employer, as opposed to an insurance company, assumes responsibility for payment of all eligible benefits.
- **Preferred provider organization (PPO).** A plan that provides coverage through a network of participating health care providers. Enrollees may receive services outside the network, but at higher costs. The additional costs may be in the form of

higher deductibles, higher coinsurance rates, or both, or nondiscounted charges from providers.

- **Exclusive provider organization (EPO).** A plan that obligates employees to use their providers exclusively to receive coverage, in contrast to PPO benefit plans, which merely offer a financial incentive for enrollees to use the preferred provider. An EPO is a specific type of PPO plan that can be either self-insured or insured through an insurance company.
- **Point-of-service plan (POS).** A plan that combines features of PPOs and traditional HMOs. POS enrollees receive more generous benefits for services within the network and for specialist care authorized by their primary care physicians. Benefits are less generous for care received outside the network and for self-referrals.

- H -

Health Maintenance Organizations (HMOs): HMOs assume both the financial risks associated with providing comprehensive medical services and the responsibility for delivering health care in a particular geographic area, usually in return for a fixed, prepaid fee from members. HMOs emphasize preventive care and cover most types of care in full or subject to a copayment.

Traditional HMOs. An HMO that provides no benefits for services obtained outside the network.

Open access HMOs. An HMO that allows enrollees to receive services outside the network, but at higher costs. The additional costs may be in the form of higher deductibles, copayments, or coinsurance.

- I -

Insured plan. In an insured plan, the employer contracts with another organization to assume financial responsibility for the costs of enrollees' medical claims.

- L -

Limitations on coverage:

- **Maximum dollar limit.** The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while the ensured is enrolled in the health plan. Plans can have a yearly or a lifetime maximum dollar limit. The most typical maximum limit is a lifetime amount of $1 million per individual.
- **Maximum out-of-pocket expense.** A limit on the dollar amount a group member is required to pay out of pocket during a year. Until this maximum is met, the plan and the member share in the cost of covered expenses. After the maximum is reached, the insurer pays all covered expenses, often up to a lifetime maximum.
- **Deductible.** The deductible is a fixed dollar amount that an insured person pays during the benefit period-usually a year-before the insurer starts to make payments for covered medical services. Plans may have both individual and family deductibles. Some plans have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission. Deductibles may differ

between services received from an approved provider (that is, a provider with whom the insurer has a contract or an agreement specifying payment levels and other requirements) and those received from providers not on the approved list.

- **Coinsurance.** This form of medical cost sharing requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, is paid. After any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits, up to the maximum allowed charges. The individual is responsible for any charges in excess of what the insurer determines to be "usual, customary, and reasonable." Coinsurance rates may differ between services received from an approved provider and those received from providers not on the approved list.
- **Overall limits.** The NCS uses this term to refer to restrictions that apply to all or most benefits under the plan, as opposed to selected individual benefits. An example of an overall limit is a $300 per year deductible that must be paid before medical expenses become eligible for reimbursement. Another example is an 80-percent coinsurance that applies to all categories of care except outpatient surgery.
- **Internal limits.** An internal limit applies to individual categories of care-for example, a $250 per procedure deductible for inpatient surgery.

- M -

Medical care. Medical care plans provide services or payments for services rendered in the hospital or by a qualified medical care provider.

- P -

Premium. A premium is the fee paid for coverage of medical benefits for a defined period. Premiums can be paid by employers, unions, or employees or can be shared by the enrollee and the plan sponsor.

Prescription drugs: Prescription drug plans provide coverage for outpatient prescription drugs. Prescription drugs dispensed during a hospital stay are covered as hospital miscellaneous charges.

- **Name-brand drugs.** These are drugs that once were, or still are, under patents.
- **Generic drugs.** These are drugs that are not under patent. Once a drug's patent has expired, some plans provide more generous coverage for same-formula generic drugs than for name-brand drugs; the practice is adopted as a cost containment measure.
- **Mail-order drugs.** These are drugs that can be ordered through the mail. As a cost containment measure, some plans use mail-order pharmacies that typically provide a 3-month supply of maintenance drugs.
- **Formulary drugs.** These are drugs approved by the health care provider. Drugs not approved by the health care provider are nonformulary drugs, for which enrollees receive less generous benefits, such as a higher copayment per prescription.

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- S -

Self-insured plan. Under this type of plan, employers directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured plans insure against large claims through the purchase of stop-loss coverage. Some self-insured plans contract with insurance carriers or third-party administrators for claims processing and other administrative services; other self-insured plans are self-administered.

Substance abuse treatment: Substance abuse treatment plans provide at least partial payment for inpatient institutional treatment (in a hospital or specialized facility) for addiction to alcohol or drugs. To be a benefit, drug abuse or alcoholism treatment must include an impatient confinement.

- **Detoxification.** This treatment involves supervised care by medical personnel that is designed to reduce or eliminate the symptoms of chemical dependency. Treatment can occur on an inpatient or an outpatient basis.
- **Rehabilitation.** These services are intended to alter the behavior of substance abusers and usually are provided after detoxification is complete. Services can be provided on an inpatient or outpatient basis.

- V -

Vision care. Vision care plans provide coverage for the nonsurgical improvement of eyesight, including coverage for eyeglasses and contact lenses. Coverage typically is limited and is subject to applicable copayments or scheduled cash allowances.

- W -

Well baby care. A well baby care benefit provides for preventive doctors' visits for children 2 years of age and younger. The benefit includes preventive pediatric care, routine pediatric care, and routine pediatric immunizations. Care immediately after the birth of the child is not included