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Questions for the PharmacistRx

A guide to important and commonly used health insurance terms.

Insurance policies are generally confusing to most people and health insurance policies are no different. Here are some important terms that you should know.

COBRA

Consolidated Omnibus Budget Reconciliation Act – This is a federal law that may allow you to keep health coverage temporarily after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. In this case you pay 100% of the premiums, including the share the employer used to pay, and an administrative fee.

Coinsurance

This is a percentage of the costs of a covered health care service that you pay after you have paid your deductible.

Copay

This is a fixed amount you pay for a covered health care service after you have paid your deductible.

Coverage Gap (Donut Hole)

Medicare Part D prescription drug coverage plans have a coverage gap also known as the Donut Hole. This means that after you and your drug plan have spent a certain amount of money for

covered drugs, you must pay out-of-pocket costs up to a yearly limit. Once you get to the limit, the coverage gap ends and your drug plan helps pay for covered drugs again.

Deductible

This is the amount you must pay for your covered health care services before your insurance plan starts to pay.

Formulary

This is the list of prescription drugs covered by a prescription drug plan.

Health Benefits

These are the items and services covered by your insurance plan.

In-Network

This is a provider who has a contract with your health insurance or plan to provide services.

Insurance Premium

This is the amount you pay for your health insurance every month. This is separate from the deductible, copayments, and coinsurance.

Lifetime limit

This is a cap on the total benefits you may get in your lifetime from your insurance company. It may be a total lifetime dollar limit on benefits, a limit on specific benefits or a combination of the two. Once a lifetime limit is reached, the insurance plan will no longer pay for covered services.

Network Plan

This is a health plan that contracts with doctors, hospitals, pharmacies, and other health care providers to provide members of the plan with services and supplies at a discounted price.

Open enrollment period

This is the yearly period when people can enroll in a Marketplace health insurance plan. For Medicare, it is November 1 – January 15. It is usually different for job-based plans.

Outside Open Enrollment, you may still be able to enroll in Marketplace coverage if you have certain life events, like getting married, having a baby, or losing other health coverage, or based on your estimated household income.

You can apply and enroll in Medicaid or the Children's Health Insurance Program (CHIP) any time of year.

Out-of-pocket cost

This is what you pay for medical care that isn't reimbursed by insurance. It includes deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Out-of-pocket maximum

This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance for in-network care and services, your health plan pays 100% of the costs of covered benefits.

The out-of-pocket limit doesn't include your monthly premiums, out-of-network services, what you spend for services your plan doesn't cover and costs above the allowed amount for a service that a provider may charge.

Plan Year / Policy Year

This is the 12-month period of benefits coverage under a group health plan. In a lot of cases, it may not be the same as the calendar year.

Pre-existing condition

This is a health condition like diabetes, asthma, cancer, or other condition you had before the date that new health coverage starts. Insurance companies can't refuse to cover treatment for your pre-existing condition or charge you more.

Preferred Provider

This is a provider who has a contract with your health insurer or plan to provide services to you at a discount. If you use a non-preferred provider, you may have to pay more.

Prior Authorization

This is an approval that may be required from a health plan before you get a service or fill a prescription for the service or prescription to be covered by your plan.

Preventive Services

These are health care services that include screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Qualifying life event

This is a change in your situation like getting married, having a baby, death in the family, moving to a different county, or losing health coverage that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the yearly Open Enrollment Period. There are more examples not listed.

Total cost estimate for health coverage

This is the total amount you may have to pay for health plan coverage, which is an estimate before you actually have the coverage and have health expenses under the coverage. In general, it includes your premium, deductible, out-of-pocket expenses, copayment, and coinsurance.

Wellness program

It is a program offered through a workplace to improve and promote health and fitness. It allows employers or a plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate.

Some examples of wellness programs include programs to help you lose weight, stop smoking, help with managing diabetes, and offer preventative health screenings.

Worker's compensation

This is an insurance plan that employers need to have to cover employees who get injured on the job.

Disclaimer: This is not an exhaustive list and is for information only.