# DEMYSTIFYING HEALTH INSURANCE: ONE WORD AT A TIME

Help employees take charge of their coverage by helping them learn the language of health care.

**Health insurance.** It's a tricky dialect. And if you're not fluent, enrollment can feel like a giant mystery. But you're in luck: We're here to help you decipher it.

Want to demystify open enrollment season? Give your employees the chance to learn key terms year-round. We've built this glossary to be your quick-access reference. With our help, your workforce can have a better understanding in no time.

## Annual out-of-pocket maximum

An annual out-of-pocket maximum is the most you'll pay for covered health expenses in a plan year. Once you hit your annual out-of-pocket maximum, your health plan pays 100 percent of covered health expenses for the rest of the plan year.

*Annual out-of-pocket maximum*

## Authorization

Authorization means approval. Many health plans require you to get authorization before certain medical services, like a hospital stay or outpatient procedure. Authorization can also be called prior authorization or pre-certification.

**To make sure that your care is authorized, call us at the number on the back of your ID card — or chat with a representative on myCigna.com.**

**Authorization is also known as...**

- Certification
- Pre-certification
- Prior authorization

## Beneficiary

A beneficiary is a person who is eligible to receive health coverage under a plan. It could be the person who signed up for the plan, or their covered dependents, like their spouse or kids. For life insurance plans, a beneficiary is the person who will receive payment should the person who bought the plan die.

*Beneficiary*

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*Benefit*

## Claim

A claim is a payment request from you or your health care provider to your health plan for covered services. In other words, it's what you or your doctor sends your health plan carrier to get paid.

## Coinsurance

Coinsurance is the portion of the cost you pay for covered health services after your health plan starts to pay. This usually happens once the deductible has been met. Coinsurance can also refer to the percentage of covered expenses paid by your health plan.

## Consumer driven health plan (CDHP)

A consumer driven health plan, or CDHP, is a type of health plan that combines a high annual deductible with lower monthly premiums/plan contributions and a tax-advantaged personal account. This account is usually either a health reimbursement account (HRA) or a health savings account (HSA).

## Copay

A copay is the dollar amount you have to pay for a covered health care service under the terms of your health plan. It's usually due at the time you receive the service, at a doctor's appointment or for a medical procedure.

## Benefit

This is an important term to know. A benefit is an item or service that's covered by your health plan. For example, preventive care is a benefit under most health plans.

## Carrier

A carrier is a licensed insurance company (like Cigna Health and Life Insurance Company.) Carrier can also refer to a health maintenance organization (HMO) or a third-party administrator (TPA).

### Copay vs. coinsurance

**Copay** is a flat fee. For example, if your plan includes a $30 copay for doctor's visits, your bill will be $30 every time.

**Coinsurance** is a percentage of the total. For example, if your plan includes 20% coinsurance for treatment, then your bill will be different each time. Your 20% of the total will change as the total cost of the care changes.

**...But what about a deductible?**
Your deductible is an amount that you have to pay before your health plan will begin paying a portion of covered expenses. For example, if your plan has a $1000 deductible for the year, then every time you go to the doctor, you'll pay the total bill — until all those bills have added up to $1000. After that, your plan kicks in and, depending on which type of health care plan you have, you'll pay a portion of covered costs for any care that comes afterward.

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## Coverage

Coverage is the benefits a health plan provides you, and any covered dependents, for certain health expenses.

## Customer ID

Your customer ID is the unique identifier associated with a health plan customer. Your customer ID is usually printed on your health plan ID card. It's often a series of numbers and letters.

## Deductible

A deductible is the amount you pay each year before your plan begins to pay. Once the deductible has been met, your health plan starts to pay a share of the covered costs.

### What's the difference between a beneficiary and a dependent?

A beneficiary is anyone covered under your plan. That includes you. It also includes anyone in your family that's on your health plan. A dependent is anyone besides you that's getting coverage — i.e., kids, spouse, partner.

*Dependent*

## Dependent

A dependent is a person who depends on you for health coverage. It's usually a spouse, partner or child. If you're enrolled in a health plan, a dependent may be eligible for coverage under your plan because of their relationship with you.

## Effective date

Your activation date, also called your effective date or coverage start date, is the date your health plan starts. For example, you might enroll in your employer's health plan on July 15 but have an activation date of September 1.

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## Employee assistance program (EAP)

An employee assistance program, or EAP, is a program that provides short-term counseling or helps you find resources for issues like managing stress, grief and substance abuse. It's an assessment and referral program. That means you talk to a representative about your concern and they help refer you to the right resources. An EAP can be pre-purchased by an employer. It is typically available to their employees plus their dependents and other household members at no extra cost.

*Explanation of benefits*

## Identification (ID) card

This is the card given to all health plan customers by their health insurance company or health plan carrier. Your ID card helps doctors and other health care providers confirm that you have coverage and that you're eligible under your plan to receive coverage for their services.

## In-network

In-network refers to the doctors, hospitals, labs and other providers that a health plan contracts with to provide discounted rates to its health plan customers. You typically pay less when you see in-network providers.

## Inpatient care

Inpatient care is the type of care you receive when you're admitted to a hospital, extended-care facility, nursing home or other similar health care facility for one night or longer.

## Exclusions and limitations

Exclusions and limitations are exceptions to your insurance policy or plan coverage. An exclusion is a condition or situation that is not covered by your plan. A limitation may limit benefits to a certain amount or for a certain amount of time.

## Explanation of benefits

An explanation of benefits, or EOB, is a statement sent by the health plan carrier that explains what medical treatments and or services were paid for. It's an explanation of your benefits for a particular service.

*Inpatient care*

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*Network*

## Network

A network is a group of doctors, hospitals, labs and other health care professionals that have contracted with a health plan to deliver health care services to its customers. Usually, the providers in a network offer a discounted rate to health plan customers.

## Non-network provider

A non-network, or out-of-network, provider is a doctor, hospital, lab or other type of health care provider who isn't part of your health plan's contracted network. Some plans provide coverage when using a non-network provider. However, you'll typically pay more for these services than if you were to stay in-network.

## Open enrollment

Open enrollment is a time during the year when you can buy or change your health care coverage, either through your employer or on your own. The dates for open enrollment vary, depending on how you get your coverage. For many people, open enrollment takes place sometime during the fall.

## Out-of-pocket maximum

An out-of-pocket maximum is the most you'll pay out of your pocket for covered health care costs in a year, according to the terms of your health plan. Depending on the plan, this amount may include money spent on deductibles, copays and coinsurance. Once you meet your out-of-pocket maximum, your health plan pays all covered health care costs for the rest of the year.

## Plan year

A plan year is the twelve months during which your health plan is active and providing you with benefits. The twelve months don't necessarily follow the calendar year. For example, your plan year can be from July 1 to June 30.

*Plan year*

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## Premium

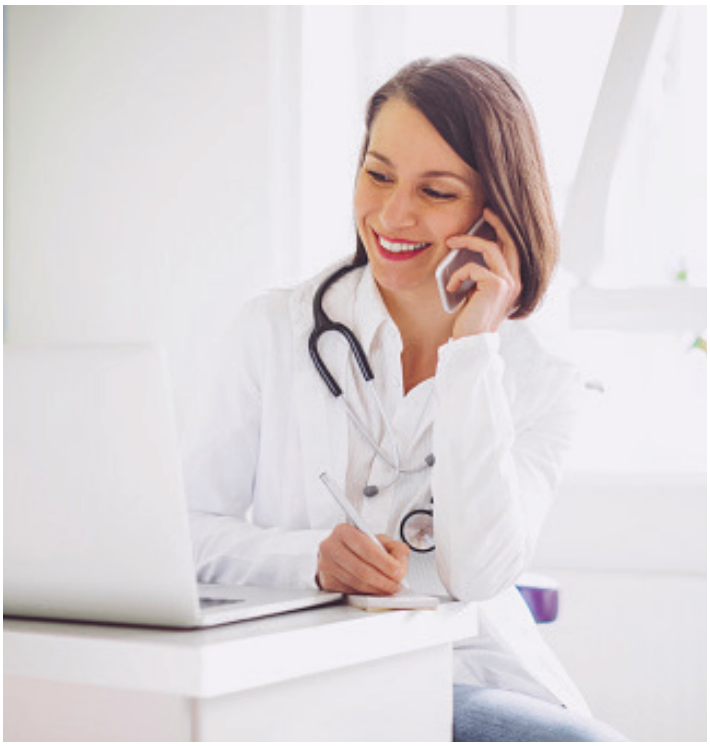
A premium is the required monthly payment you make to your health insurer for your health plan. If you have coverage through your employer, your premium cost is typically deducted from your paycheck each pay period.

## Primary care provider (PCP)

A primary care provider, or PCP, is a health care provider that provides a broad range of routine medical services. A primary care provider refers patients to specialists, hospitals and other health care providers as necessary. A primary care provider is usually a family or general practitioner, internist or pediatrician. Some types of health care plans require you to choose a primary care provider and get a referral before seeing a specialist.

## Provider

A provider is another term for doctor, hospital or another health care professional or facility that provides health care services.



*Referral*

### Provider

✓ **Is my dermatologist a health care provider?**
Yep!

✓ **What about my pharmacist?**
You bet.

✓ **The nurse practitioner?**
Absolutely.

✓ **Physical therapist?**
Affirmative.

✓ **Midwife?**
Indeed!

✗ **Barista?**
....No.

## Referral

A referral is a recommendation from your doctor or health care provider to go see another health care provider for additional care, treatment or a consultation. Many health plans require you to get a referral from your regular doctor or primary care provider before you can see a specialist.

## Summary of benefits

A summary of benefits is the document from your health insurance company or health plan that gives you a brief list of your plan's coverage and the cost sharing you'll be responsible for when you go for services.

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# LEARN YOUR ABCs

Health care documents can be an alphabet soup of acronyms. Learn what the most common abbreviations mean so you and your employees can navigate your plans. Let's dig in.

**AD&D:** Accidental death and dismemberment
**ALOS:** Average length of stay
**ASC**: Ambulatory surgery center
**Auth:** Authorization
**CDHP:** Consumer Driven Health Plan
**CIN:** Clinically integrated network
**COB:** Coordination of benefits
**COI:** Certificate of insurance
**DME:** Durable medical equipment
**DOS:** Date of service
**E&L:** Exclusions and limitations
**EAP:** Employee assistance program
**EMT:** Emergency medical technician
**EOB:** Explanation of benefits
**EOC:** Evidence of coverage
**ER:** Emergency room
**FFS:** Fee for service
**FMLA:** Family and Medical Leave Act
**FSA:** Flexible spending account
**HDHP:** High-deductible health plan
**HIPAA:** Health Insurance Portability and Accountability Act
**HMO:** Health Maintenance Organization
**HRA:** Health Reimbursement Account
**HSA:** Health Savings Account
**ICU:** Intensive Care Unit
**IRF:** Inpatient reading fee
**LOS:** Length of stay
**LPN:** Licensed practical nurse
**LTD:** Long term disability
**MOOP:** Maximum out-of-pocket
**Non-par:** Not participating (out-of-network)
**NPI:** National provider identifier
**OOA:** Out of area
**OOP:** Out-of-pocket
**OTC:** Over-the-counter drugs
**OV:** Office visit
**PCP:** Primary care provider
**PHA:** Personal Health Assessment
**PHI:** Protected health information
**PPO:** Preferred Provider Organization
**Pre-auth :** Pre-certification
**Pre-x:** Pre-existing conditions
**QHP:** Qualified health benefits plan
**Remit:** Remittance
**ROI:** Release of information
**TPA:** Third-party administrator
**UCC:** Urgent care center

Didn't see the term you were looking for? We've got more. **Find the full glossary at Cigna.com.**

And while you're there, check out our helpful resources for more tips, common questions and best practices to better engage in your benefits plan. Don't forget: We're here to help.

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