

## **HEALTH CARE DEFINITIONS**

### **GLOSSARY OF TERMS**

#### **Brand-Name Drug**

Manufacturers patent brand-name drugs, so that only they can produce and sell them—often at a high price. When the patent expires, other manufacturers are permitted to produce these drugs as generics, and often sell them at a much lower price.

#### **Coinsurance**

The percentage of reasonable and customary charges that you pay for a covered service under one of the Medical Trust medical plans after you meet the applicable annual deductible. PPO and POS plans typically require that you pay coinsurance, while HMOs and EPOs do not.

#### **Copayment**

A fixed dollar amount that you pay for in-network office visits, emergency room visits, and certain other medical plan services, as well as prescription drugs.

#### **Deductible**

The amount you are responsible for paying in certain medical plans before the plans begin to pay for covered services. Generally, HMOs and EPOs do not have deductibles.

#### **Exclusive Provider Organization (EPO)**

Under this type of plan, you agree to use the health care professionals and facilities associated with the EPO. As with health maintenance organizations (HMOs), except in emergencies, the EPO does not cover the cost of services you receive from doctors or other providers outside the network. There are no deductibles or claim forms. After a copayment for each office visit, most expenses are covered at 100%. You must select a primary care physician (PCP) to coordinate your care.

#### **Formulary**

A list of prescription medications preferred by a health plan. The medications are selected based on clinical effectiveness and opportunities to help contain a health plan's costs. Formulary lists are usually subject to periodic review and modification by the health plan.

#### **Generic Drug**

A prescription drug that is chemically equivalent to a brand-name drug that is no longer protected by a patent. Generic drugs are typically sold at a lower price than the brand-name equivalent.

### **Health Maintenance Organization (HMO)**

This type of medical plan often offers only in-network benefits. With HMOs, generally there are no deductibles or claim forms. You pay a copayment for each office visit, then most other expenses are covered at 100%. You must select a primary care physician (PCP) in an HMO.

### **High Deductible Health Plan/Health Savings Account (HDHP/HSA)**

Your coverage consists of two components under this type of plan: a traditional plan with a high deductible (except for some preventive care) and a tax-advantaged savings account. The High Deductible Health Plan works much like a PPO plan. You and your employer fund the Health Savings Account, which you may use to pay for medical expenses. If you do not use the money in your HSA, it continues to grow with tax-free earnings to use for future medical expenses.

### **In-Network**

Network providers and facilities have agreed to provide services to participants at negotiated rates. When you receive care from a network provider or in a network facility, you will pay these lower, in-network, rates for services. In certain plans, in-network services require only a co-payment.

### **Out-of-Network**

If you receive care from a physician or in a facility that is not part of your medical plan's network, you will be responsible for more of the cost of the care. Using non-network providers means that you are receiving out-of-network care.

### **Out-of-Pocket Maximum**

The maximum amount you are responsible for paying in one plan year for covered expenses.

### **Point-of-Service (POS) Plan**

Under this type of plan, you can visit any provider you choose. However, if you coordinate care through your primary care physician (PCP) and utilize the plan's network, you will receive a higher level of benefits. Care received out-of-network will generally be covered at a reduced level.

### **Preferred Provider Organization (PPO)**

With this type of medical plan, you don't need to select a primary care physician (PCP) and you don't need a referral to visit a specialist. You receive plan benefits regardless of the doctor or facility you use. However, if you choose to receive care within the plan's network, you will generally receive a higher level of benefits coverage.

**Primary Care Physician (PCP)**

The physician responsible for coordinating your care with specialists under most managed care medical plan options.

**Qualified Status Change**

You are generally eligible to make changes to your benefit elections during the annual enrollment period. However, the IRS states that you may be eligible to make changes during the plan year on account of certain qualified status changes. These include events such as marriage, divorce, the birth or adoption of a child, and the death of a covered dependent.

**Reasonable and Customary (R&C)**

Determined by the individual insurance carriers, this amount refers to the typical charges made by providers of similar standing and expertise for similar procedures in a particular geographic area. R&C guidelines are used by carriers to determine the maximum amount they will pay for certain services covered under their plans. Typically, R&C charges apply only to plans that offer out-of-network benefits.