

# Health Plan Definitions

**Allowed Amount** - The portion of a medical bill under the plan which is eligible for benefits.

**Billed Amount** - The amount the provider has charged for services rendered.

**Certificate of Creditable Coverage (COCC)** - A document which verifies your participation in a health plan. A COCC is needed when you enroll in a new health plan. The COCC tells your new plan if you have had continuous coverage. This information is used for determining if a subscriber is subject to the pre-existing clause or not.

**Claim** - An itemized bill which includes procedure codes, diagnosis codes, charges, number of units, patient name and address as well as provider billing information.

**Co-Insurance** - A percentage of the allowed charges which the subscriber is responsible for paying. This is usually in addition to the deductible.

**Co-Payment** - A set amount which a subscriber must pay for certain services. This is usually separate from the deductible and co-insurance.

**Deductible** - An amount the subscriber is responsible for before the benefit plan benefits apply. Example: The allowed amount is \$1,000, the subscriber's deductible is \$500 and the plan calls for a \$25 co-payment. The subscriber would pay \$525 (co-payment + deductible) and the plan would pay \$475.

**Exclusion** - Services or charges that are not eligible for coverage under the health plan.

**Explanation of Benefits (EOB)** - A statement sent to the subscriber listing claims and payment information.

**Explanation of Payment (EOP)** - A statement sent to the provider showing benefit determination.

**Out-of-Pocket** - The maximum amount of eligible charges a subscriber is responsible for paying in a plan year. This is usually the deductible and coinsurance combined. Example: The plan deductible is \$500 and the maximum out-of-pocket is \$1,000. Once the member's deductible and the amounts paid in coinsurance reach a total of \$1,000, the plan would then pay 100% of the allowed charges for the remainder of the plan year.

Note: in most plans, copays do not apply towards the maximum out-of-pocket.

**Preferred Provider organization (PPO)** - An organization which contracts with providers for a discounted rate on claims. A PPO allows a person to see any physician they choose, however, claims are paid at a lower benefit level if the subscriber uses a provider outside the PPO network.

**Pre-Certification** - Some services may require prior approval. This is referred to as pre-certification or pre-authorization. When a plan requires prior approval, failure to obtain approval may result in a reduction in benefits.

**Pre-Existing Condition** - A chronic medical condition for which the subscriber was diagnosed or treated for prior to participation in the health plan. Pre-existing conditions may be excluded from coverage. A subscriber may be subject to pre-existing if there has any been a gap in coverage greater than 63 days.

**Provider** - Doctor, clinic, nurse, pharmacy, hospital or medical equipment supplier.

**Third Party Administrator (TPA)** - An organization which takes on the administration of health care benefits for a plan, primarily processing claims in accordance with the benefit plan the employer has designed.



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