LEARNING YOUR HEALTH PLAN'S VOCABULARY CAN SAVE YOU MONEY

Here are explanations (and proper spellings) for some of the most commonly misunderstood health coverage terms, where they fit into your overall coverage and how understanding them can enhance your experience with your plan.

These terms are commonly used when discussing health plan types:

Preferred Provider Organization (PPO) Plan

A type of health plan that contracts with medical providers —such as hospitals and doctors — to create a network of participating providers. You have less out-of-pocket costs if you use providers that belong to the plan's network; however, you can use doctors, hospitals, and providers outside of the network but higher out-of-network costs will be applicable.

Exclusive Provider Organization (EPO) Plan

A managed care plan where services are covered only if you go to doctors, specialists or hospitals in the plan's network (except in an emergency).

High Deductible Health Plan (HDHP)

A plan with a higher deductible than a traditional insurance plan because it is designed to be used with a health savings account (HSA) allowing you to pay for certain medical expenses with money free from federal taxes. While the monthly premium is usually lower for an HDHP, you will pay more health care costs yourself (your deductible) before the insurance company starts to pay its share. All of GuideStone's HDHPs are considered HSA-Qualified High Deductible Health Plans by the IRS and are designed to be combined with an HSA.

MEDICAL PLAN VOCABULARY

These are the terms you're most likely to see in relation to discussions about what is and isn't covered by your health plan.

- **BENEFIT:** This describes the portion of your claims costs that are covered by your health plan. Understanding your benefits can help you predict the portion of a claim your plan will pay.

- **CLAIMS:** These are your health care expenses that are filed with your insurer to request payment. In most cases, the claims are filed by your medical provider. Create an account on your health provider's website to monitor your claims as they move through the payment process and review the Explanation of Benefits (EOBs) provided by your plan.

- **CO-INSURANCE:** This term refers to the percentage of costs of a covered health care service for which you are responsible. For example, if your co-insurance is 20% and your providers submit a claim for $10,000, your portion will be $2,000 and your health plan will pay $8,000. Co-insurance, deductibles and co-pays make up the total costs you pay toward a claim.

- **CO-PAY:** This fixed, out-of-pocket payment is made by the plan participant at the time a medical service is rendered. For example, there will be a co-pay for a doctor's office visit or a prescription refill. Co-pays, deductibles and co-insurance make up the total costs you pay toward a claim.

- **DEDUCTIBLE:** Generally speaking, a deductible is the predetermined amount of money a participant pays on claims before the plan starts to pay. There are two general categories of deductibles:

  - **EMBEDDED DEDUCTIBLE:** Each individual on your health plan has his or her own deductible. These embedded (individual) deductibles also accumulate toward an aggregate (family) deductible. For example, if your plan provides coverage for two adults and two children with embedded deductibles of $2,000, each person will have his or her own individual $2,000 deductible or reach the aggregate (family) deductible before benefits are paid at the co-insurance level.

  - **AGGREGATE DEDUCTIBLE:** An aggregate deductible is a set amount that either one individual or all family members can contribute toward. For example, if the aggregate deductible is $2,000 per individual or $6,000 per family, you will have to meet the $2,000 deductible for individual-only coverage (no dependents on the plan). If you have dependents on the plan, the individual deductible goes away completely and you are responsible for contributing toward a family deductible.

PRESCRIPTION PLAN VOCABULARY

These terms help describe the prescription benefits included in your medical plan.

- **FORMULARY:** Also known as a preferred formulary, this is a list of prescription drugs covered by your health plan. Most formularies include generic prescription and brand-name drugs. Physicians use the formulary to determine which drugs are most effective at the best possible price. The formulary is a living document and will change as new drugs enter the market. You can find the formulary on your prescription provider's website. Working with your physician to choose prescriptions that are part of the formulary will lower your out-of-pocket costs.

- **TIERED PRICING:** Co-pays for prescription drug prices are differentiated by the levels, or tiers. Tier 1 is generally the lowest co-pay and is for generic drugs. Tier 2 is generally reserved for preferred brand-name drugs. Tier 3 is usually non-preferred or specialty drugs for which members will pay the largest co-pay. Request Tier 1 drugs from your physician to keep your costs low through the payment process.

PROVIDER VOCABULARY

There are a variety of medical providers from which you can receive care.

- **NETWORK:** Health care providers who agree to work with a health plan to provide services to those in the plan at discounted rates are considered to be a part of a network. Keep your costs low by choosing a provider within your health plan's network where you will receive the deepest discounts.

- **PRIMARY CARE PROVIDERS:** This type of doctor or medical practitioner provides preventive and routine care. These can be pediatricians, family practice physicians, obstetricians/gynecologists and internal medicine doctors. Developing a relationship with a primary care provider can help you stay healthy.

- **SPECIALIST:** A doctor or medical practitioner with advanced training in a specific subset of care is considered to be a specialist. You will usually see these physicians only for a short term. Work with your primary care provider to find a specialist who understands your condition and is in your health plan.

Learning your health plan's vocabulary can help you navigate your benefits and find the lowest-cost, best-quality care.

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