Learning Your Health Plan's Vocabulary Can Save You Money

Familiarizing yourself with health plan terminology can help clarify your coverage and enhance your health care journey. Here are some frequently misunderstood terms.

Common Types of Health Plans

Preferred Provider Organization (PPO) Plan

A type of health plan that contracts with health care providers — such as hospitals and doctors — to create a network of participating providers. Choosing in-network providers reduces out-of-pocket costs. You can use providers outside the network, but it generally costs more.

Exclusive Provider Organization (EPO) Plan

A managed care plan that only covers services when you go to doctors, specialists or hospitals in the plan's network (except in emergencies).

High Deductible Health Plan (HDHP)

A plan with a higher deductible than a traditional health care plan because it is designed to be used with a Health Savings Account (HSA), which allows you to pay for qualified medical expenses with money free from federal taxes. While the monthly cost is usually lower for an HDHP, there are higher out-of-pocket costs before meeting the deductible. Once the deductible is met, the health plan begins 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.

Vocabulary for Health Plan Features

These terms are used to describe what is and isn't covered by a health plan.

Benefit: This refers to a health care service that is covered by the health plan. Familiarizing yourself with benefits can help you understand how much your plan will pay for a claim.

Claims: These are health care costs that are filed with your health care provider to request payment. In most cases, the claims are filed by your health care provider. Create an account on your health provider's website to monitor claims throughout the payment process and review the *Explanation of Benefits* (EOB) for accuracy.

Co-insurance: This is the amount a plan pays for eligible services after the deductible is met. For example, a plan may have 80%/20% co-insurance. This means that after the deductible is met, the plan will pay 80% and the plan member will pay 20% of future costs. Co-insurance, deductibles and co-pays make up the total costs you pay toward a claim.

Co-pay: This is a flat amount a plan member pays for a health care service or prescription medication. Co-pays, deductibles and co-insurance make up the total costs you pay toward a claim.

Deductible: This is the amount a plan member pays out-of-pocket before the plan's co-insurance kicks in. The lower the deductible, the more the health plan typically costs. There are two general types of deductibles:

- **Embedded Deductible:** Each dependent 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 individual only, with no dependents on the plan, you are responsible for only meeting that amount. If there are employee and dependents on the plan, the deductible to be met is $6,000 and you will be required to meet the full family amount.

Prescription Plan Vocabulary

These terms help describe the prescription benefits included in a health plan.

Formulary: Also known as a preferred formulary, this is a list of prescription drugs covered by a health plan. Most formularies include generic prescription and brand-name drugs. Health care providers use the formulary to determine which drugs are most effective at the best possible price. The formulary is regularly updated to include new drugs as they enter the market. You can find the formulary on your prescription provider's website. Ask your health care provider to choose prescriptions on the formulary to minimize your out-of-pocket costs.

Tiered Pricing: Co-pays for prescription drugs are differentiated by levels known as tiers. Tier 1, which generally has the lowest co-pay, is for generic drugs. Tier 2 is typically reserved for preferred brand-name drugs. Tier 3, which is usually for non-preferred or specialty drugs, typically has the highest co-pay. Request Tier 1 drugs from your health care provider to help minimize costs low through the payment process.

Provider Vocabulary

These are the types of providers that offer health care services.

Network: Health care providers who agree to offer discounted rates to health plan members are considered in-network providers. Minimize health care costs by choosing providers within your plan's network.

Primary Care Providers: This type of health care provider provides preventive and routine care. This includes pediatricians, family practice physicians, obstetricians/gynecologists and internal medicine doctors. Developing a relationship with a primary care provider can help you promote your health.

Specialist: This is a doctor or medical practitioner with advanced training in a specific area of care. Work with your primary care provider to find a knowledgeable specialist who is part of your health plan.

Need more help understanding your plan? Contact us at *Insurance@GuideStone.org* or **1-844-INS-GUIDE** (1-844-467-4843), Monday through Friday, from 7 a.m. to 6 p.m. CT.

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