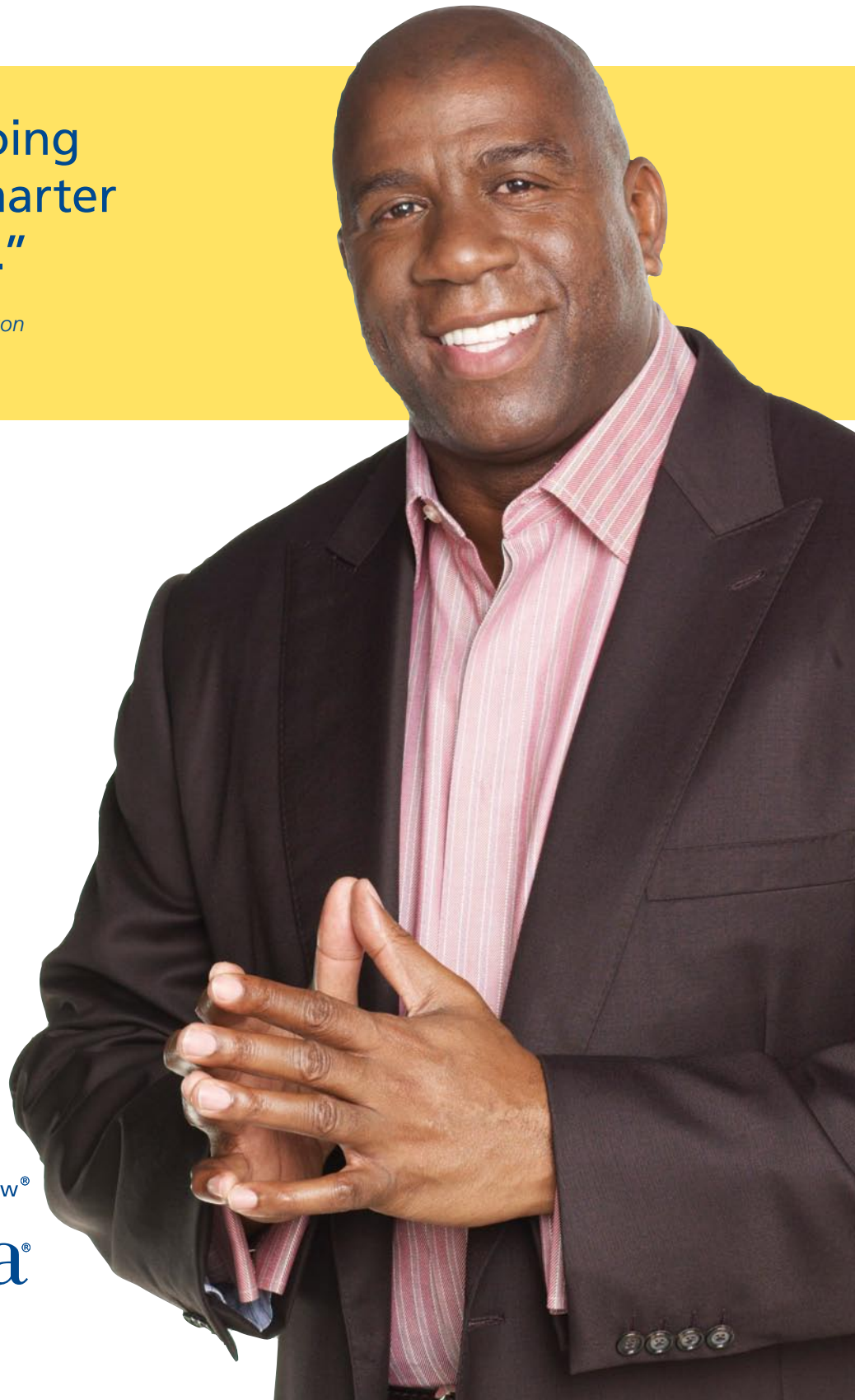


Health Insurance 101

Words to know when you need
medical care

**"Together, we're going
to help you get smarter
about your health."**

– Earvin "Magic" Johnson



We want you to know®



It takes a winning strategy to keep you and your family healthy. Aetna[‡] — along with its newest teammate, Earvin “Magic” Johnson — can help.

We’ll give you an assist by helping you learn the language of health insurance. Together, we created this glossary of key health insurance terms. We want you to use it often, so you can become familiar with some of the words you’ll hear when you get medical care.

When you understand these terms, you will be one step closer to the information you need to make smart health care choices — choices that can keep you and your family on the winning track.

Aetna and Magic Johnson Enterprises

A

Accreditation

A process in which managed care companies (like Aetna) are evaluated on the quality of their services. They are judged on how they perform against a list of specific standards. The evaluation is done by a group called the National Committee for Quality Assurance (NCQA).

Adjudication

A process used by health plans to determine how much it will pay for health care expenses that are covered by your plan.

Appeals Process

Sometimes a health plan reviews a claim and denies payment for the medical service you got. An appeals process lets you ask for a second review of your claim.

B

Benefits

The specific medical services that are covered by your health plan.

Brand-Name Drug

A medicine made by a pharmaceutical company that is the first to develop it. Because it is the first to develop it, the company can protect the drug with a patent. So, no other company can make the same medicine while the patent lasts. You need a prescription from your doctor to get a brand-name drug.

C

Case Management

A process used by health plans to identify members with complex health care needs and coordinate that care so the member can improve his or her health.

Certificate of Coverage

A document you get after you enroll that describes the specific benefits, limits and exclusions of your health plan.

Claim

Information that is sent to your health plan requesting payment for medical services you received. Usually, it is your doctor who sends the claim.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

A law that lets you continue to participate in your company’s health plan when you would otherwise lose eligibility because you lost your job or have a change in family status (typically, divorce).

Coinsurance

A percentage of your covered health care expenses that you pay. This means the amount you pay can vary from one visit to the next. It is often paid after you meet your annual deductible (if you have one). Your health plan pays the rest.

Consumerism

A health care practice that helps you get the information you need to make informed health care choices. This includes knowing the real cost of health care. It is part of a new trend that requires you to take an active part in managing your own health care costs.

Coordination of Benefits

A process that helps health plans determine which plan will pay benefits first, when you are covered under two separate plans. This is common when your spouse has a separate health plan.

Copayment

A set dollar amount that you pay for your covered health care expenses. The amount you pay for each visit does not vary. It is often paid after you meet your annual deductible (if you have one).

Covered Health Care Expenses (Also “Eligible Expenses”)

Medically necessary health care services that are “covered” by your health plan or that are “eligible” to be paid by your health plan.

D

Deductible

A fixed dollar amount you pay for your covered medical services before your health plan pays benefits.

Denied Claim

A claim sent by your doctor to your health plan that your health plan does not pay because of the rules of your plan.

Dependent

A person who can be covered by your health plan because of his or her relationship to you (usually a child or spouse).

Direct Access (Also “Open Access”)

Health plans in which you can go directly to a participating provider in the plan’s network without a referral.

Disease Management

A program to identify members with a chronic illness. This is done to help them manage their symptoms and avoid future health problems.

[‡]Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna). Community Vitality is a health literacy initiative for the public from Aetna and Magic Johnson Enterprises.

Duplicate Coverage

When you or one of your dependents has coverage for the same health care service with more than one health benefits plan.

E

Effective Date

The date your health plan takes effect. Look for it on your ID card.

Emergency

A serious illness, injury or health issue that comes on at once. It is also something that a person with an average knowledge of health thinks must be treated right away to avoid loss of life, serious health risk or permanent disability.

Exclusion

A condition or service that is not covered by your health plan.

Explanation of Benefits (EOB)

A brief report that explains what services (benefits) your doctor billed your health plan for and how the services were paid. It can be sent to you by mail or e-mail.

F

Fee for Service

A process that lets health plans pay doctors and other providers a fee for each service they provide.

Formulary

A list from your health plan of the prescription drugs it covers at the highest benefit level. Most plans that cover prescription drugs use a formulary. How much a plan covers may vary from drug to drug.

Fully Insured Employer

An employer who pays a premium to a health plan provider to provide health plans for its employees is “fully insured.” This means the health plan, not the employer, is responsible for paying the health care claims.

G

Generic Prescription Drugs

A drug that has the same active ingredients as a brand-name drug for which the patent has expired. Generic drugs usually cost less than the brand-name version.

Group Coverage

Health benefits for employees, former employees and their families that are paid for by an employer or employee organization.

H

Health Maintenance Organization (HMO)

A health plan that arranges health care services for its members. Members choose a primary care physician (PCP) from a network. The PCP gives routine care and refers members to network doctors if special care is needed.

Health Reimbursement Arrangement (HRA)

A new type of health plan that lets you use a fund to pay for your health care costs. Your employer puts money into a fund. You use it to pay your deductible, coinsurance and other covered health care costs.

Health Risk Assessment

An online questionnaire or tool to help you find out how healthy you are. It also helps you see if you are at risk for future illnesses by answering a series of questions.

Health Savings Account (HSA)

A new type of health plan that lets you put money into a health savings account. You can use the account to pay for covered health care costs. Or, you can save the account for future health care expenses. The account grows interest.

High-Deductible Health Plan

A health plan with a deductible and benefits that are high enough to meet the federal rules that let a plan member contribute to an HSA (see above).

I

Indemnity Plan (Also “Traditional Plan”)

A health plan that lets members get care from any licensed provider. Members get the same level of benefits. These plans often include deductibles, coinsurance, benefit maximums and lifetime maximums (see definitions in this glossary).

Individual Policy

A health plan bought by an individual who is either self-employed or is not offered health benefits by his or her employer.

L

Lifetime Maximum

A limit on the number of visits your health plan will cover for a treatment or therapy, or a dollar limit on the amount of coverage the plan will allow in your lifetime.

Limitations

Provisions in a group benefits plan that limits coverage in certain situations. They let you know what your plan does not cover.

M

Mail Order Pharmacy

A service that lets you order prescription drugs through the mail. Your order is sent to your home. Your health plan may have lower copayments if you use mail order delivery.

Maintenance Medication

Drugs that are prescribed for the long-term treatment of chronic illnesses such as diabetes or high blood pressure.

Medically Necessary

Medical care or supplies that your health plan agrees you need to treat an illness or injury. These are described in the covered benefits section of your plan documents. Your health plan’s decision on what is medically necessary is based on the results of clinical research or accepted medical standards.

N

Network (Also “Provider Network”)

A panel of doctors and health care providers who contract with a health plan to provide services. Usually, they charge health plan members a special rate. With some plans, you get more coverage when you see a network provider.

Nonparticipating Provider (Also “Out-of-Network Provider”)

Doctors, hospitals and other health care professionals who do not have a contract with your health plan to provide health care services. You may pay more when you visit one of these providers.

O

Open Access (Also “Direct Access”)

Some health plans let you go directly to a participating provider without a referral. In other words, they give you “open access.”

Open Enrollment

A period of time when you can choose, or change, a health plan for you and your dependents for the following year.

Out-of-Pocket Costs

The amount you have to pay for health care services covered by your health plan. Copayments and deductibles are examples.

Out-of-Pocket Maximum

A limit on how much you have to pay for medical care covered by your health plan.

Outpatient Care

Care you get at a hospital or facility for which you do not have to stay overnight.

Over-the-Counter Drug

Medicine you can get without a prescription from your doctor.

P

Participating Provider (Also “Network Provider” or “Preferred Provider”)

A doctor, hospital or health care professional who has a contract to participate in your plan’s network. You may get higher coverage (so you pay less) when you visit a participating provider.

Personal Health Record

A safe and private record of your health history that you can see on a computer. Some information will be added by your health plan. This includes: 1) claims they get for your care, 2) information about your last doctor visit, and 3) treatment prescribed by your doctor. In some cases, you can add information on your own. This includes: 1) family health history, 2) blood type, and 3) diet and exercise information.

Plan Documents

A set of materials your employer and health plan have that describe the details of your health plan. It lets you know what is covered, what is not covered, and what you will pay for covered services. Ask your employer for a copy.

Point-of-Service Plan (POS)

A health plan that lets you get care from a primary care physician (PCP), another provider in the network, or *any* provider. You usually get higher coverage (you pay less) when you see your PCP and lower coverage (you pay more) when you go to other providers.

Preauthorization (Also “Precertification”)

A process in which your health plan requires you or your health care provider to get approval for certain medical services before agreeing to cover the service.

Pre-existing Condition

A physical or mental condition that exists before your insurance begins.

Preferred Provider Organization (PPO)

A health plan that lets you see any health care provider. These plans usually give higher coverage (you pay less) when you see doctors or hospitals in the PPO plan’s network.

Premium

The amount paid for a fully insured health benefits policy. If you get benefits through your employer, the premium is often shared between you and your employer.

Prescription Drug

A drug you can only get with an order form from your doctor.

Preventive Care

Health care services or programs that help you stay healthy or help detect early signs of disease. For example, annual physical exams and immunizations help you stay healthy. Mammograms and cancer screenings help detect early signs of disease.

Primary Care Physician/Primary Care Provider (PCP)

A doctor you choose to be your point of contact for health care. He or she gives basic care and coordinates special care when it is needed. This is usually a family care doctor. It can also be a pediatrician or Ob/Gyn.

Provider

A licensed doctor or health care professional who provides health care services.

R

Referral

A form your PCP gives you so you can get coverage for care from a specialist or health care facility. It may be mailed as a written form or sent by computer.

Reimbursement

A payment you get from your health plan for covered costs you paid to your doctor. The amount depends on the deductible, copayment or coinsurance requirements in your health plan.

S

Second Opinion

An opinion you get from a second doctor, after you receive an opinion from the first doctor you went to see. It gives you a chance to compare the two opinions and decide how you want to treat your problem.

Self-Insured Employer

An employer who chooses to pay health care claims for its employees is “self-insured.” The health benefits company manages the payments.

Service Area

The area where a health plan has a license to operate. Or, when a license is not needed, the area where a network of doctors is available to give health care services that are covered by a health plan.

Specialist

A doctor who gives medical care in a specific category (for example: dermatologist, oncologist).

Subscriber

The person covered under an employer’s health benefits policy. If an employer makes family coverage available, the subscriber can add eligible dependents to the plan.

U

Urgent Care

Medical care you receive for a sudden illness or injury that is not life threatening but does require immediate care to avoid severe pain, suffering or complications.