Definitions

Acquire Date

The acquire date is the date that establishes a relationship between you and your dependents, such as date of marriage for a spouse, date of birth for a natural child or date of legal obligation if you are appointed as a guardian.

Allowance

Allowance is the maximum amount a plan will pay for a covered healthcare service.

Ambulatory Surgical Center

An ambulatory surgical center is a healthcare facility that provides surgical services and is either licensed as an ambulatory surgical facility by the state in which it is located, or operated by a hospital licensed by the state in which it is located. An ambulatory surgical center generally does not provide accommodations exceeding 12 hours.

Balance Billing

Balance billing is the process of billing a patient for the difference between the medical service provider's actual charges and the amount that the provider will be reimbursed from the patient's insurance benefits plan. When obtaining services out of network, members can be subject to balance billing by the out-of-network provider. For example, let's say that a doctor typically charges $100 for a certain service. An in-network doctor has agreed to provide the same service for a reduced rate of $75. An out-of-network provider has not agreed to any reduced rates, as they do not have a contract with the insurance carrier and will bill the entire charge of $100. However, the insurance carrier will not reimburse more than $75 for the service, which means that you will owe the out-of-network provider the additional $25.

Claims

Claims are the bills received by the plan after a member obtains medical services.

Coinsurance

Coinsurance is a share of the cost for covered healthcare services, calculated as a percentage of the allowed amount for those services. Unlike a fixed copay, coinsurance varies depending on the allowed amount for a service.

Consumer-driven Health Plan

A consumer-driven health plan, or CDHP, is a type of medical insurance or plan that typically has a higher deductible and lower monthly premiums. Typically, you take responsibility for covering minor or routine healthcare expenses until your deductible is met. Once you meet your deductible, coinsurance applies.

Copay

A copay is a flat dollar amount that you pay for certain services like office visits and prescriptions.

Deductible

A deductible is a fixed dollar amount you must pay each year before the plan pays for services that require coinsurance.

Drug Tiers

The drugs covered by the state's pharmacy benefit are grouped into tiers — generic, preferred brand, non-preferred brand and specialty. Each tier has a different payment amount. All health plans do not include all drug tiers.

Formulary

The formulary is the list of drugs your health plan covers. The pharmacy benefits manager reviews this list and makes changes each quarter.

Fully Insured Plan

Under a fully insured plan, an insurance company, rather than a group sponsor (like the state) pays all claims. The sponsor pays a premium to the insurance company. The state's dental and vision plans are fully insured.

Generic Drug

A generic drug is a Food and Drug Administration approved copy of a brand-name medicine. It has the same ingredients and works the same way. Generic drugs are safe, effective and high quality. They usually cost the least, so you pay less when you choose a generic.

Guaranteed Issue

Guaranteed issue means you cannot be denied coverage and do not have to answer questions about your health history as long as you enroll within a certain amount of time.

Head of Contract

The head of contract is someone who can make coverage elections and has authority to change coverage elections. Two married employees who both work for participating employer groups could each be the head of their own contract or one could be the head of contract and the other a covered dependent spouse

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act is a federal law that governs portability between health plans, special enrollment provisions and privacy and security of protected health information.

In-network Care

In-network care is provided by a network provider. Costs for in-network care are usually less expensive than out-of-network care as a result of special agreements between insurance carriers and providers.

Inpatient

Inpatient is someone who is admitted to a hospital or treatment facility, given a bed, charged for room and board and stays **more than 23 hours** for care.

Maximum Allowable Charge

The maximum allowable charge, known as the MAC, is the most that a plan will pay for a service from an in-network provider. If you go to an out-of-network provider who charges more than the MAC, you will pay your cost share, which may include a copay or deductible and coinsurance, plus the difference between the MAC and the actual charge.

Meeting Your Deductible

Meeting your deductible means you have reached your annual deductible. This is the amount you pay each year before the plan pays for services that require coinsurance.

Negotiated Rate

The negotiated rate is the amount that participating providers agree to accept as full payment for covered services.

Network

A network is a group of doctors, hospitals and other healthcare providers contracted with a health insurance carrier to provide services to plan members for set fees.

Non-preferred Brand Drug

A non-preferred brand drug is a name-brand medicine that isn't on your health plan's preferred list. Your plan still covers it, but it usually costs more because there are other brand or generic drugs your plan suggests using first.

Out-of-network Care

Out-of-network care refers to healthcare services from a provider who is not contracted with your insurance carrier. Costs for out-of-network care are usually more than for in-network care. The benefits paid are usually based on the maximum allowed by the plan. When out-of-network charges are higher than the maximum allowed, the member pays their out-of-network share of the cost, plus the difference between the provider's charges and the allowed amount.

Out-of-pocket Maximum

An out-of-pocket maximum is the most you will pay for services in any given year. The out-of-pocket maximum does not include premiums. Once you reach your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the year. There are separate maximums for in-network and out-of-network services. There is also a separate out-of-pocket maximum for in-network specialty pharmacy drugs. The different out-of-pocket maximums do not cross accumulate.

Outpatient

Outpatient is any person receiving medical treatment or services on a basis other than as an inpatient.

Plan Year

The plan year is the 12-month period beginning Jan. 1 and ending Dec. 31.

Preferred Brand Drug

A preferred brand drug is a name-brand medicine that your health plan covers at a lower cost. These medicines work well and are offered at a better price to help you save money.

Preferred Provider Organization

A preferred provider organization, or PPO, gives plan participants direct access to a network of doctors and facilities that charge pre-negotiated and typically discounted fees for the services they provide to members. Plan participants may see any doctor or specialist in the network without a referral. The benefit level covered through the plan typically depends on whether the member visits an in-network or out-of-network provider when seeking care.

Premium

The premium is the amount you pay each month for your coverage, regardless of whether you receive health services. What you pay depends on where you work (state, higher education, local education or local government), the benefit option you select and the level of coverage you choose.

Preventive Care

Preventive care is routine healthcare, including screenings, check-ups and patient counseling, to prevent or discover illness, disease or other health problems. You do not pay a copay, deductible or coinsurance for in-network preventive care.

Primary Care Physician

Primary care physician, also known as a PCP, refers to your regular medical doctor. This is the doctor you see most often. A PCP can be a general practitioner, a doctor who practices family medicine, internal medicine, pediatrics or an OB/GYN. Nurse practitioners, physician's assistants and nurse midwives (in a licensed healthcare facility only) may also be considered primary care providers when working under the supervision of a primary care physician.

Self-insured Plan

Under a self-insured plan, a group sponsor like the state or an employer, rather than an insurance company, is financially responsible for paying the plan's expenses, including claims and plan administration costs. The state's health insurance plans are self-insured.

Special Enrollment Provision

A rule that allows people to request enrollment in insurance benefits beyond the initial eligibility period due to certain life events.

Special Qualifying Event

A personal change in status, such as divorce or loss of employment, which may allow someone to change benefit elections.

The Plan

In the broadest sense of the word, the plan is the applicable State of Tennessee Group Insurance Program. Plan may also refer to specific group plans within the larger comprehensive plan, such as the state plan, the local education plan or the local government plan.