Health insurance glossary

Health insurance is complex, and Alnylam Assist™ is here to help you better understand your coverage. **Below is a glossary of common terms to help you navigate your health insurance.**

Affordable Care Act (ACA)
The comprehensive health care reform law enacted in March 2010 by President Barack Obama (sometimes known as ACA or "Obamacare").

Allowed Amount / Maximum Allowable
The maximum dollar amount that your plan will pay for covered health care services.

Appeal
A request which is typically made to a health insurer by you or your provider to review and reconsider a coverage decision.

Balance Billing
When a physician bills you for the difference between the physician's charges and the amount that is allowed by your plan (i.e., allowed amount). Patients are not typically responsible for this cost when services are in-network and covered.

Benefits
The health care services (e.g., office visits, diagnostic tests, etc.) and items (e.g., prescription drugs) that are covered by your insurance plan.

Claim
The document your physician submits to your health insurance company to receive payment for services provided.

Coinsurance
The percentage of costs of a covered health care service or item that you are responsible for paying generally after you have paid any deductibles required by your plan.

Commercial Health Insurance
Health insurance administered by a private entity rather than a government agency. You may receive commercial insurance through an employer (nearly half of Americans receive commercial insurance through their job), or you can purchase health insurance directly from an insurance carrier, through federal marketplace or through an insurance broker.

Coordination of Benefits
If you have more than one health insurance plan, the plans work to determine their respective payment responsibilities for a claim.

Copayment
A set dollar amount that you pay for a specific health-related service, such as a doctor's visit or prescription drugs.

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Formulary / Drug List
A list of prescription drugs covered by your health insurance plan. Formularies are typically divided into tiers or levels of coverage with defined cost sharing that increases for higher-tier drugs.

Example 5-tier plan

Tiers:

1	preferred generic drugs (lowest cost)
2	non-preferred generic drugs and preferred brand-name drugs
3	non-preferred brand-name drugs
4	preferred specialty drugs
5	non-preferred specialty drugs (highest cost)

Cost Sharing
The amount you pay out-of-pocket for health care services covered by your health insurance plan, after the plan determines their respective payment responsibilities for a claim. This includes copayments, coinsurance and deductibles, but does not include premiums (with the exception of Medicaid and the Children's Health Insurance Program), balance billing amounts for out-of-network care, or the cost of non-covered services.

Deductible
A set amount that you must pay each benefit year before your health insurance plan will start to pay for most covered health services. After your deductible is met, you are typically only responsible for a copayment or coinsurance for covered services.

Dual-Eligible Beneficiaries
Beneficiaries who are enrolled (or eligible to enroll) in both Medicaid and Medicare. Dual-eligible beneficiaries typically have limited cost sharing and may qualify for assistance with Medicare premiums.

Employer-Sponsored Health Insurance / Group Health Plan
An insurance policy selected by the employer and offered to eligible employees and their dependents.

Explanation of Benefits (EOB)
A notice that summarizes the services, charges, and payment for services you have received. An EOB is not a bill, although it may look like one.

Flexible Spending Account (FSA)
An account, typically arranged through your employer, that lets you pay for many medical expenses with tax-free dollars.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
A federal law that protects sensitive patient health information from being disclosed without the patient's consent.

Health Maintenance Organization (HMO)
A health insurance plan that provides care for members through a defined network of providers and hospitals. Under an HMO, members are typically required to select a primary care provider (PCP) and obtain referrals for specialists, and out-of-network care is typically not covered (except in an emergency).

Health Reimbursement Arrangement (HRA)
Employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year.

Health Savings Account (HSA)
A type of savings account for high deductible health plan (HDHP) beneficiaries that lets you set aside money on a pre-tax basis to pay for qualified medical expenses (e.g., deductibles, copayments, coinsurance, and some other expenses). HSA funds generally may not be used to pay premiums.

Medicare
A government program that provides health insurance for individuals 65 years or older and certain people with disabilities under the age of 65.

High Deductible Health Plan (HDHP)
Health insurance plans with relatively low monthly premiums and high deductibles. With a HDHP, preventative care may be covered in full prior to meeting your plan's deductible. For 2023, the IRS defines a high deductible health plan as any plan with a deductible of at least $1,500 for an individual or $3,000 for a family.

In-Network / Preferred Provider
A provider who accepts your insurance and has contracted with the health plan to provide services at a discounted rate. Some plans may have a tiered network where you pay extra to see select providers.

Medicaid
A joint state and federal government insurance program that provides free or low-cost health insurance to some low-income people, families and children, pregnant women, the elderly, and people with disabilities.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. Medical services generally must be considered medically necessary in order to be covered by insurance. Your health plan may request additional information from your physician to confirm whether a treatment is medically necessary.

Medicare currently offers four different insurance programs: Parts A, B, C, and D

PART A

Includes:

- Hospital inpatient services
- Hospice care
- Certain home health services
- Qualified skilled nursing facility care

PART B

Includes:

- Procedures in the physician office and hospital outpatient settings
- Physician services in all settings of care
- Office- and hospital outpatient-administered drugs
- Laboratory tests
- Ambulance services
- Durable medical equipment (DME)

PART C

- Privately managed alternative to Medicare Fee-for-Service (or Original Medicare)
- Private healthcare plans (primarily managed care plans) offer combined Part A and Part B Medicare benefits
- Part C is also known as Medicare Advantage (MA)

PART D

- Prescription drugs
- Part D benefits can be offered as standalone Prescription Drug Plans (PDPs) or Medicare Advantage-Part D prescription drug plans (MA-PDs)

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Pre-Authorization/ Prior Authorization / Pre-Determination / Pre-Certification

A request submitted (typically by a physician) to your health insurance plan prior to treatment to determine if specific health care services or items are considered medically necessary by your plan. Some plans may require one of these for certain services before you receive them; however, these requests are not promises that your health insurance or plan will cover the cost.

Medigap

A supplemental insurance policy sold by private insurance companies to help fill gaps in Original Medicare by covering some outstanding medical costs beyond what is paid for by Medicare (e.g., copayments, coinsurance, and deductibles).

Open Enrollment Period

The time of year when you are able to sign up for a health insurance plan for the following year. If you are not satisfied with your current health plan, the open enrollment period may be the only opportunity to switch to a different plan.

Out-of-Network / Non-Preferred Provider

A provider who has not contracted with your health insurance plan. Out-of-pocket costs are typically higher for out-of-network care; in some cases, you may be responsible for the full cost when you see an out-of-network provider.

Out-of-Pocket Limit / Maximum Amount

The amount you will have to pay for covered services in a plan year. After this amount is met, the health insurance will pay 100% of the costs for covered services. The out-of-pocket limit often excludes:

- Your monthly premiums
- Anything you spend for services that your plan does not cover
- Office visit copay
- Out-of-network services
- Costs above the allowed amount for a service that a provider may charge (i.e., balance billing)

Pre-Existing Condition

A disability or illness that you have been treated for before enrolling in a new health plan.

Preferred Provider Organization (PPO)

A health insurance plan with a defined network of providers and hospitals where patients can access services at a lower cost when compared to out-of-network care. Under a PPO, members may be able to go to specialists without a referral from a PCP and obtain out-of-network care for an additional cost.

Premium

The amount that you pay to your health insurance plan for coverage (generally on a monthly basis).

Primary Care Provider (PCP)

A physician, nurse practitioner, nurse specialist, or physician assistant that provides and coordinates your care. Some health plans (e.g., HMOs) may require that you go through your PCP to get a referral to specialists.

Referral

A written order (i.e., prescription) from your PCP to see a specialist or to get certain medical services. Health Maintenance Organizations (HMOs) often require a referral before you can get medical care from anyone other than your PCP (without a referral, your plan may not pay for the services).

Specialty Drug

Typically a high-cost drug to treat serious, chronic, rare, or life threatening diseases. These drugs may have special storage or shipment requirements and require additional education and support from a health care professional.

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Subsidized Coverage
Health coverage available at reduced or no cost for people that meet certain income eligibility requirements.

Special Enrollment Period (SEP)
A time outside of the annual open enrollment period when you can enroll in a health insurance plan if you've had a certain life event, such as marriage, birth of a child, or loss of health insurance coverage (for example, due to losing a job).

Specialist
A provider that focuses on specific areas of medicine rather than a general practitioner.

Specialty Pharmacy
Pharmacies that are able to distribute specialty drugs. They are typically equipped to handle specialty products that may have unique storage or handling requirements and may provide patient support beyond a traditional pharmacy including coordination of care and disease management program. Some payers may require you to obtain specialty drugs through a "preferred" or in-network specialty pharmacy or pay an additional cost to use an out-of-network specialty pharmacy.

Supplemental / Secondary Insurance
An additional health insurance plan that helps pay for services and/or out-of-pocket costs that are not covered by your main health insurance plan.

These definitions have been adapted from the following sources:

Healthcare.gov. Glossary. Available at: https://www.healthcare.gov/glossary/

Medicare.gov. What's Medicare Supplement Insurance (Medigap)? Available at HSAs, FSAs, and other types of job-based coverage https://www.healthcare.gov/job-based-help/#/coverage

Medicare.gov. Glossary. Available at: https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap

CMS. What's Medicare Supplement Insurance (Medigap)?. Available at: https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap

CMS Medicare Learning Network. Dually Eligible Beneficiaries Under Medicare and Medicaid. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

AMCP. Managed Care Glossary. Available at: https://www.amcp.org/about/managed-care-pharmacy-101/managed-care-glossary

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Questions about your health insurance?
Alnylam Assist™ may be able to help:

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Monday–Friday, 8AM–6PM
: 1-833-256-2748

For more information about Alnylam Assist™ or to access downloadable materials, visit www.AlnylamAssist.com.

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