Glossary

Not sure what it means?

Use this glossary as a handy reference for some common health benefit terms.

Below are definitions related to Blue Shield health plan terms. Some terms may not apply to your plan. See your *Evidence of Coverage* or *Benefit Booklet* for details.

Allowable amount – The total dollar amount Blue Shield has established for the benefits the member has received. Physicians who have contracted with Blue Shield must accept this amount as payment in full. If a member chooses to go outside of our networks, he or she may be responsible for a much larger payment.

Benefits (covered services) – The medically necessary services and supplies covered by the health plan.

Copayment/coinsurance – The predetermined amount (copayment) or a percentage of the cost (coinsurance) for which you are responsible for paying, based on your plan benefits.

Deductible – The dollar amount you must pay for covered services each calendar year before Blue Shield starts paying benefits under your plan. You are responsible for this amount. Specific services, such as preventive care, are covered before you reach the calendar-year deductible.

You may have two kinds of deductibles: medical and pharmacy. Your medical deductible applies to covered services such as physician office visits. Your pharmacy deductible applies to outpatient prescription drugs obtained from a participating provider.

Evidence of Coverage* or *Benefit Booklet – The official Blue Shield documents that describe member benefits, copayments or coinsurance, exclusions and limitations.

Network providers/participating providers/provider network – A provider (includes doctors, hospitals, urgent care centers, etc.) that has agreed to contract with Blue Shield to provide covered services to members of a given health plan. A participating provider has agreed to accept Blue Shield's contracted rate for covered services.

Out-of-pocket maximum – Your maximum copayment or coinsurance responsibility each calendar year for covered services. Copayments or coinsurance for a small number of covered services do not apply to the annual out-of-pocket maximum. You will continue to be responsible for copayments or coinsurance for these services even after you reach the out-of-pocket maximum.

Prescription drug formulary – The list of preferred medications maintained by Blue Shield for its prescription drug benefits. This list includes both generic and brand-name drugs approved by the Food and Drug Administration (FDA).

Prescription drug tiers – Prescription drugs in a formulary are typically grouped into tiers based on defined categories, such as generic drugs, preferred brand-name drugs, non-preferred brand-name drugs, and specialty drugs. The tier that your medication is in determines your portion of the drug cost. A typical drug benefit includes three or four tiers. You can find information about what you pay by drug tier in your health plan documents.

Prior authorization – Some services require prior authorization before treatment, in addition to your doctor's referral. A referral and a prior authorization are two different things. For example, when your primary care physician cannot give you the treatment you need, he or she refers you to a specialist. However, if you require a hospital stay or certain surgical procedures, radiological treatments, etc., Blue Shield of California must authorize these medical services before you can receive them. Before receiving such services, call the Member Services or Shield Concierge number on the back of your Blue Shield member ID card to obtain a prior authorization.

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