Common Health Plan Definitions

Use these definitions to refresh your knowledge and to help Members understand and use their benefits more effectively.

Referral: Request by a Provider to refer you to another Provider. Referrals may be verbal, written, or digital.

Physician Order/Prescription: An order a Provider gives you on paper or as a digital file for you to get a service or medication.

Authorization: Approval for services from Prime EHP Utilization Management. Authorization approvals are sent to Providers by fax or online. You will receive approvals by mail at your home.

Summary Plan Description (SPD): A summary of your health plan benefits and coverage, including but not limited to covered services, excluded and limited services, cost sharing, and prior authorization requirements.

Deductible: A monetary limit paid for health care services before health plan assumes the cost of the medical procedures or services. If the plan covers more than one person, there may have family and individual deductible limits.

Copay: A relatively small, fixed amount that must be paid to the Provider at the time of visit.

Co-Insurance: A percentage of costs of the allowed amount for covered and approved services paid by Member until their out-of-pocket maximum is met.

Out-of-Pocket Maximum (OOP): A predetermined amount that a Member must pay before health plan will pay the entire costs of the allowed amount for covered and approved services for the remainder of the plan year.

OOP is reset every plan year. If the plan covers more than one person, there may have a family and individual OOP. Amounts that are paid for health care services which are not included in the plan's benefit do not go towards their OOP. The monthly premium payments, if applicable, do not go towards your OOP.