

# Common Self-Funded Terms

## A Comprehensive Glossary

Below are common self-insurance terms and their definitions to help members, employers, and other stakeholders understand their plans and options.

- 1. Administrative Services Only (ASO):** An ASO arrangement allows a third-party administrator to handle plan administration, while the employer funds claims.
- 2. Aggregate Stop-Loss:** Aggregate stop-loss insurance covers total claims costs that exceed the employer's projected annual claim liability.
- 3. Aggregating Specific Corridor:** An aggregating specific corridor is the dollar threshold to meet before specific stop-loss applies.
- 4. Allowed Amount:** An allowed amount is the maximum fee a health insurance plan will pay for a covered service, which may affect out-of-pocket costs.
- 5. Case Management:** Case management coordinates care for members with complex health needs.
- 6. Claim:** A claim is a request submitted to a health insurance provider for payment of covered medical services or expenses.
- 7. Claims Corridor:** The Claims corridor refers to the range within which employers cover claims before stop-loss begins.
- 8. Claims Lag:** Claims lag is the time between service provision and claim payment.
- 9. Claims Reserve:** Claims reserve is funds set aside by employers to cover future claims not yet paid.
- 10. COBRA:** COBRA is a federal law that allows individuals to temporarily continue their employer-sponsored health insurance coverage after losing their job or experiencing certain life events.
- 11. Coinsurance:** Coinsurance is the percentage of covered costs paid by members after meeting their deductible.
- 12. Contract Period:** The contract period is the timeframe in which plan terms and coverage apply, usually one year.
- 13. Contract Type:** Contract type defines claims coverage terms, typically based on when claims are incurred and paid.
- 14. Coordination of Benefits (COB):** COB determines the primary payer when a member has multiple coverage plans.



- 15. Copayment:** A copayment is a fixed amount a patient pays for a medical service or prescription, with the remaining cost covered by their health insurance.
- 16. Credibility:** Credibility measures the reliability of a group's historical claims data for setting expected claims or premiums.
- 17. Deductible:** Deductible is the amount a member must pay before the plan starts covering expenses.
- 18. Disease Management:** Disease management supports members in managing chronic conditions, improving health, and reducing costs.
- 19. Dual-Option:** Dual-option plans provide employees with two health coverage choices, such as varying deductibles or networks.
- 20. Employee Contribution:** Employee contribution is the portion employees pay for premiums, typically via payroll deduction.
- 21. Eligibility Roster:** The eligibility roster is the list of employees and dependents eligible for health coverage.
- 22. Employer Contribution:** Employer contribution is the portion of premium costs covered by the employer, helping fund employee health benefits.
- 23. Expected Claims:** Expected claims are the projected annual claims based on historical data and plan factors.
- 24. Exclusions:** Exclusions are specific services or conditions a plan does not cover.
- 25. Explanation of Benefits (EOB):** An EOB, or Explanation of Benefits, is a statement from a health insurance plan detailing what was billed, what is covered, and any remaining patient responsibility.
- 26. Fiduciary Responsibility :** Fiduciary responsibility is the duty of administrators to act in plan members' best interests.
- 27. Fixed Costs:** Fixed costs are predictable plan expenses, like administrative fees and stop-loss premiums, that don't vary with claims.
- 28. Formulary:** A formulary is a list of prescription drugs covered by a health insurance plan, often organized by tiers that determine cost-sharing.
- 29. Health Reimbursement Arrangement (HRA):** An HRA is an employer-funded account that reimburses employees for medical expenses.
- 30. Health Savings Account (HSA):** An HSA is a tax-advantaged account for HDHP holders to save on medical costs.
- 31. High-Deductible Health Plan (HDHP):** HDHP is a health plan with a high deductible, often paired with HSAs.



- 32. Individual Stop-Loss:** Individual stop-loss insurance covers high-cost claims for a single member exceeding a set threshold.
- 33. Incurred But Not Reported (IBNR):** Incurred but not reported (IBNR) claims are for services provided but not yet submitted for payment.
- 34. Laser:** A laser sets a higher deductible for a specific high-risk member, requiring the employer to assume additional cost before stop-loss coverage.
- 35. Maximum Allowable Cost (MAC):** MAC is the highest amount a plan will pay for specific drugs or services.
- 36. Medical Necessity:** Medical necessity covers services essential for diagnosing or treating a condition.
- 37. Minimum Attachment:** Minimum attachment is the lowest claim threshold before aggregate stop-loss coverage begins.
- 38. Network Access Fees:** Network access fees are charges for utilizing a PPO network's discounted services.
- 39. Out-of-Pocket Maximum:** Out-of-pocket maximum is the cap on total annual expenses a member pays before full coverage applies.
- 40. Plan Document:** A plan document is a legal document detailing a self-funded health plan's terms, conditions, and benefits.
- 41. Plan Year:** The plan year is the 12-month period a health plan is active, which may differ from the calendar year.
- 42. Pharmacy Benefit Manager (PBM):** PBMs administer prescription drug benefits for health plans.
- 43. Prior-Authorization (PA):** A PA is required approval from a plan for certain services to be covered.
- 44. Preferred Provider Organization (PPO) Network:** A PPO network contracts with providers to offer plan members discounted in-network rates.
- 45. Reinsurance Carrier:** A reinsurance carrier is an insurer providing stop-loss or other risk protection for self-funded plans.
- 46. Run-Out Period:** A run-out period is the timeframe post-plan year when outstanding claims are processed and paid.
- 47. Self-Funded Plan:** A self-funded health plan is financed by the employer, who assumes financial risk for employee claims.
- 48. Specific Stop-Loss:** Specific stop-loss reimburses individual claims exceeding a set dollar amount.



- 49. Stop-Loss Insurance:** Stop-loss insurance protects employers by covering claims that exceed set thresholds.
- 50. Summary Plan Description (SPD):** SPD explains plan benefits, coverage, and exclusions to members.
- 51. Third-Party Administrator (TPA):** A TPA manages a self-funded plan's administration, including claims processing.
- 52. Usual, Customary, and Reasonable (UCR) Charges:** UCR charges are standard regional fees used to set reimbursement levels.
- 53. Wellness Program:** Wellness programs offer employer initiatives to promote health and reduce costs.