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GLOSSARY OF HEALTH COVERAGE AND MEDICAL TERMS

PURPOSE

This glossary has many commonly used terms but isn't a full list. These glossary terms are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. See your Summary of Benefits and Coverage (SBC) on how to get a copy of your policy or plan document, also known as an Evidence of Coverage (EOC).

Bold orange text indicates a term defined in this Glossary.

ALLOWED AMOUNT

Maximum allowed amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance," "maximum allowed" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

APPEAL

A request for your health insurer or **plan** to review a decision or a **grievance** again.

BALANCE BILLING

When a **provider** bills you the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. Applicable to **non-preferred providers** only; a **preferred provider** may **not** balance bill you for covered services.

CO-INSURANCE

Your share of the costs of a covered health care service, calculated as a percent (for example, 30%) of the **allowed amount** for the service. You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 30% would be \$30. The health insurance or plan pays the rest of the allowed amount.

COMPLICATIONS OF PREGNANCY

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarian section aren't considered complications of pregnancy.

CONSUMER DIRECTED HEALTH PLAN (CDHP)

Consumer Directed Health Plans (CDHPs) come in various forms, but most commonly a CDHP means offering a high-**deductible** health plan paired with a spending account for out-of-pocket expenses such as a **Health Savings Account (HSA)**. CDHPs can be offered as a **Health Maintenance Organization (HMO)**, or as a **Preferred Provider Organization (PPO)**. CDHPs encourage employees to make informed decisions and spend wisely, which typically means CDHPs enjoy a lower **premium** than traditional plans.

CO-PAYMENT

A fixed amount (for example, \$20) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service and can be dependent upon fulfilling a **deductible**.

DEDUCTIBLE

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you've met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

DURABLE MEDICAL EQUIPMENT (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetes.

EMERGENCY MEDICAL CONDITION

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

EMERGENCY MEDICAL TRANSPORTATION

Ambulance services for an **emergency medical condition**.

EMERGENCY ROOM CARE

Emergency services you get in an emergency room (ER).

EMERGENCY SERVICES

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

EVIDENCE OF COVERAGE (EOC)

The Evidence of Coverage (EOC) is a document that describes in detail the health care benefits covered by the health plan. It provides documentation of what the plan covers or excludes and how it works, including how much you pay.

EXCLUDED SERVICES

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

EXPLANATION OF BENEFITS (EOB)

An explanation of benefits (EOB) provides details about a medical insurance claim that has been processed by your **health insurance/plan**, and explains what portion was paid to the health care **provider** where you received the medical services and what portion of the payment, if any, is your responsibility. **The EOB is not a bill.** Any portion of the medical expense not covered by the insurance company, such as a **deductible** or **co-pay**, will be billed by the provider and should be paid directly to the provider.

GRIEVANCE

A complaint that you communicate to your **health insurance** or **plan**.

HABILITATION SERVICES

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include: physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of **inpatient** and/or **outpatient** settings.

HEALTH INSURANCE

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

HEALTH MAINTENANCE ORGANIZATION (HMO)

A type of health insurance plan that usually limits coverage to care from **preferred providers** contracted with the Health Maintenance Organization (HMO). These plans require you to choose a **primary care physician (PCP)** to coordinate your care and issue **referrals** to **specialists** as needed. Please note, typically you cannot see a specialist without a referral from your PCP when enrolled in an HMO.

HEALTH SAVINGS ACCOUNT (HSA)

A type of savings account that lets you put aside money on a pre-tax basis to pay for qualified medical expenses (as defined by the IRS). By using untaxed dollars in a Health Savings Account (HSA) to pay for the **deductibles**, **co-payments**, **co-insurance** and some other expenses, you can lower your overall health care costs. An HSA can be used only if you have a **High Deductible Health Plan (HDHP)**. Additionally, HSA funds roll over year to year if you don't spend them, and an HSA may earn interest, which is not taxable.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

A plan with a higher **deductible** than a traditional insurance plan. The monthly **premium** is usually lower, but you pay more for care costs before the insurance company starts to pay its share (your **deductible**). The IRS defines a high deductible health plan (HDHP) as any plan with a deductible of at least \$1,350 for an individual or \$2,700 for a family, and the **out-of-pocket limit** can't be more than \$6,650 for an individual, or \$13,300 for a family. HDHPs can be combined with a **health savings account (HSA)** allowing you to pay for certain medical expenses with money free from federal taxes.

HOME HEALTH CARE

Health care services a person receives at home.

HOSPICE SERVICES

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

HOSPITALIZATION

Care in a hospital that requires admission as an **inpatient** and usually requires an overnight stay. An overnight stay for observation could be **outpatient** care.

HOSPITAL OUTPATIENT CARE

Care in a hospital that usually doesn't require an overnight stay.

IN-NETWORK CO-INSURANCE

The percent (for example, 30%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan** (also known as **preferred providers**). In-network co-insurance usually costs you less than out-of-network co-insurance.

IN-NETWORK CO-PAYMENT

A fixed amount (for example, \$20) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

INPATIENT CARE

Medical treatment that is provided in a hospital or other facility and requires at least one overnight stay.

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.

NETWORK

The facilities, **providers** and suppliers of your health insurer or **plan** has contract with to provide health care services.

NON-PREFERRED PROVIDER

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred (or out-of-network) provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network**, which indicates a higher cost share to visit certain providers.

OUT-OF-NETWORK CO-INSURANCE

The percent (for example, 50%) you pay for the **allowed amount** for covered health care services to **providers** who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

OUT-OF-POCKET LIMIT

The most you pay during a policy period (generally a calendar year, January 1 to December 31) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover.

Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses towards this limit.

OUTPATIENT CARE

Medical treatment for a patient who is not hospitalized overnight but who visits a hospital, clinic or associated facility for diagnosis or treatment. Generally, all covered services that do not require an overnight stay are considered outpatient care.

PHYSICIAN SERVICES

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

PLAN

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

PREAUTHORIZATION

A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval, predetermination or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

PREFERRED PROVIDER

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Your health insurance or plan may have preferred providers who are “participating” providers, also considered in-network. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

PREFERRED PROVIDER ORGANIZATION (PPO)

A type of health insurance plan that contracts with medical providers that include doctors and hospitals who are all contracted with the health plan to provide services at a discounted rate. You'll save money by using **preferred providers**, although you can still use those that are out-of-network – at extra cost.

PREMIUM

The amount that must be paid for your **health insurance** or your **plan**. You and/or your employer typically pay a portion of the total premium remit to your health insurance or plan.

PRESCRIPTION DRUG COVERAGE

Health insurance or **plan** that helps pay for **prescription drugs** and medications.

PRIMARY CARE PHYSICIAN (PCP)

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

PROVIDER

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

RECONSTRUCTIVE SURGERY

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

REFERRAL

The recommendation of a medical or paramedical professional. If you get a referral to ophthalmology, for example, you are being sent to the eye doctor. In **HMOs** and other managed care schemes, a referral is usually necessary to see any practitioner or **specialist** other than your **primary care physician (PCP)**, if you want the service to be covered. The referral is obtained from your PCP, who may require a telephone or office consultation first. The term referral can refer both to the act of sending you to another medical professional, and to the actual paper authorizing your visit.

REHABILITATION SERVICES

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

SKILLED NURSING CARE

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

SPECIALIST

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

USUAL, CUSTOMARY AND REASONABLE (UCR)

The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount is sometimes used to determine the **allowed amount**.

URGENT CARE

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.