GLOSSARY OF HEALTH COVERAGE AND MEDICAL TERMS

Allowed Amount

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

Ambulatory Center/Free-Standing Facility

An entity that furnishes health care services and that is neither integrated with, nor a department of, a hospital. Physically separate facilities on the campus of a hospital are considered free-standing unless they are integrated with, or a department of, the hospital.

Examples of Freestanding Facilities include, but are not limited to, Free-Standing Cardiac Care Facilities and Free-Standing Residential Treatment Centers.

Ambulatory Surgery Centers performing covered certain services are not considered Free-Standing Facilities.

Laboratories are not considered Free-Standing Facilities.

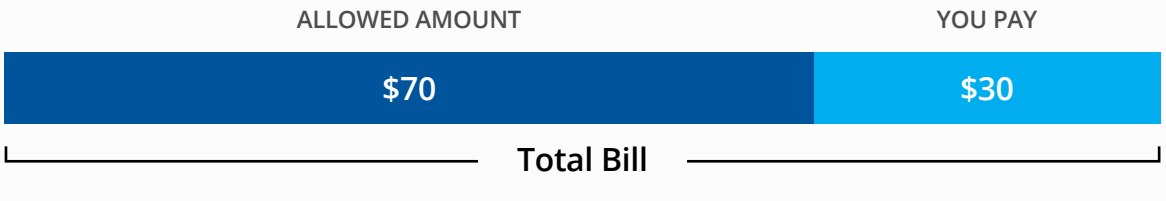
Appeal

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

Balance Billing

When a provider bills you for the difference between the provider's charge and the **allowed amount**.

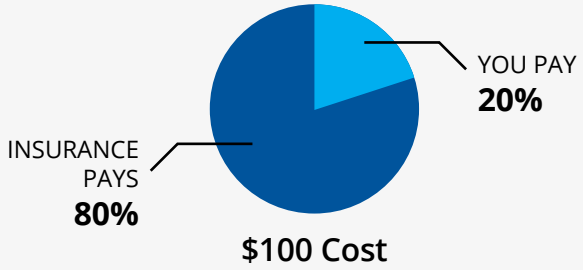
For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may *not* balance bill you for covered services.



Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance *plus* any **deductibles** you owe.

For example, if the **health insurance** allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance pays the rest of the allowed amount.



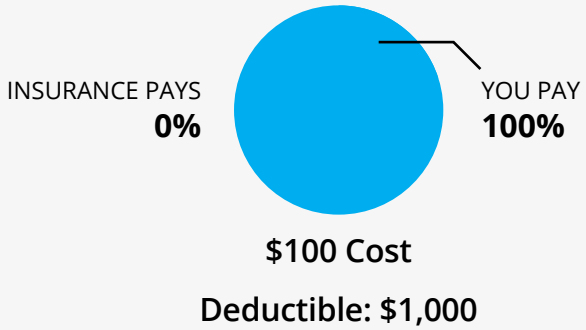
Co-payment

A fixed amount (for example, $15) 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.

Deductible

The amount you owe for covered health care services *before* your **health insurance** 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 diabetics.

Effective Date

Your **health insurance** coverage start date is the day your insurance company will begin helping to pay for your medical expenses.

Eligible Employee/ Dependent

For each **plan**, the only individuals eligible to receive tax-favored coverage are the employee, employee's spouse, and employee's qualifying dependents.

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

Care done in the Emergency Room (ER) department of the hospital. If you end up being admitted for an overnight stay, then the services would be billed under your inpatient hospital services.

Many individuals use the ER for their office visits when they are sick. This impacts the care for those who truly need **emergency services**. A better option, which would save an individual time and money, is to use an **Urgent Care** facility for a non-life threatening illness versus an Emergency Room.

Emergency Services

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

Evidence of Coverage (EOC)

The term refers to any certificate or individual or group agreement or contract issued in concurrence with the certificate, agreement, or contract issued to a subscriber. It contains information regarding coverage and other rights to which an enrollee is entitled.

Global Billing

Used in almost all cases of pregnancy claims — total charge for prenatal and postnatal services. A lump sum physician charge inclusive of all physician services, so they are not billing for every office visit for the patient (especially in the last trimester where visits can be once a week).

Grievance

A complaint you communicate to your health insurer.

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)

An organization that provides comprehensive health care to voluntarily enrolled individuals and families in a particular geographic area by member physicians with limited referral to outside specialists and that is financed by fixed periodic payments determined in advance.

Home Health Care

Health care services a person receives at home, such as wound care for pressure sores or a surgical wound, patient and caregiver education, intravenous or nutrition therapy, injections, or monitoring serious illness and unstable status.

Hospice Services

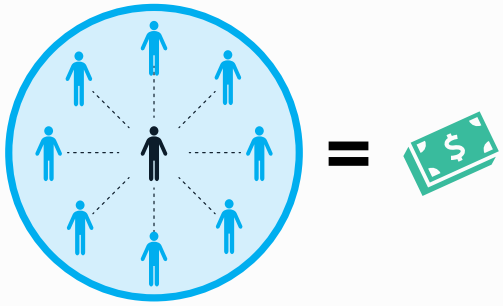
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

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 administered in the outpatient department in a hospital or facility where the patient leaves the same day. If a patient must stay overnight, the care is billed under the inpatient benefit of the patient's health plan.



In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment

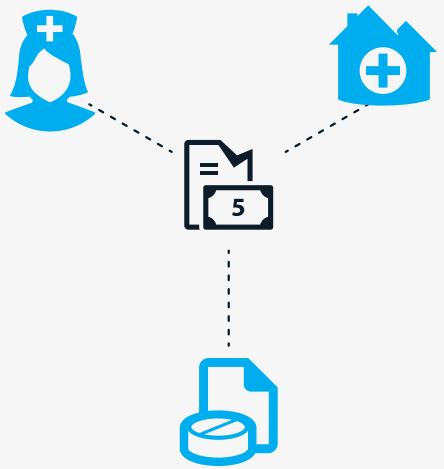
A fixed amount (for example, $15) you pay for covered health care services to **providers** who contract with your **health insurance**. In-network co-payments usually are less than **out-of-network co-payments**.

Late Entrant

Also known as late enrollee, there are certain times of the year when workers can choose or change benefits. The main time is called annual enrollment. New staff can enroll when they first begin their jobs.

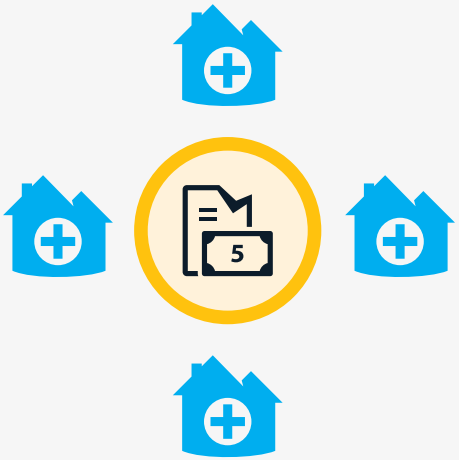
Medically Necessary

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 your health insurer has contracted with to provide health care services.

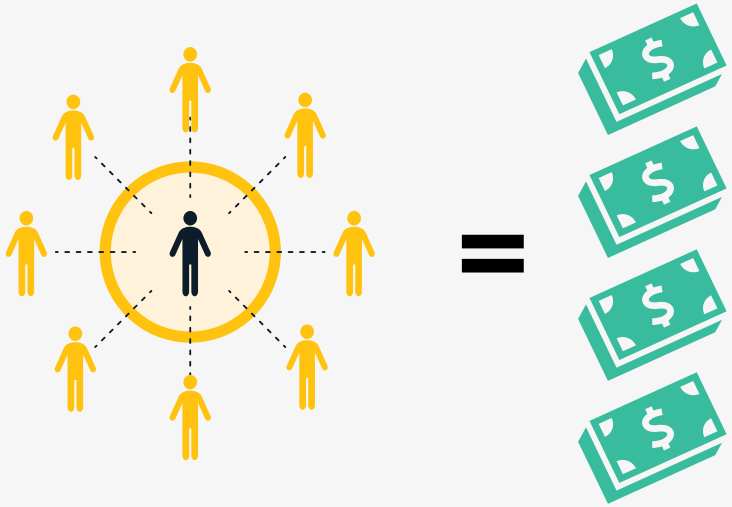


Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance, or if your **health insurance** has a "tiered" **network** and you must pay extra to see some providers.

Open Enrollment/Qualifying Life Event (QLE)

A change in your situation — like getting married, having a baby, or losing health coverage — that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the yearly Open Enrollment Period.

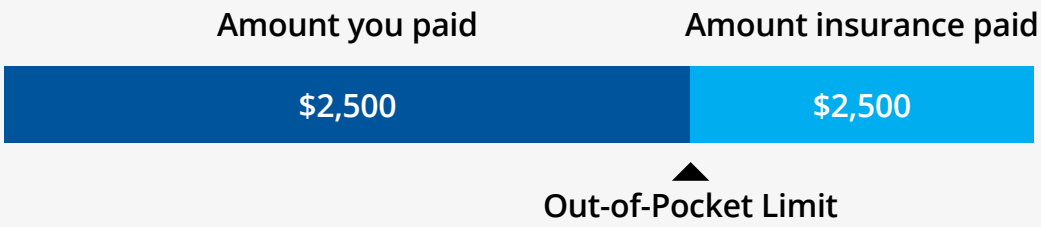


Out-of-network Co-insurance

The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do not contract with your **health insurance**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment

A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your **health insurance**. Out-of-network co-payments usually are more than **in-network co-payments**.



Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges, or health care your health insurance doesn't cover. Some health insurance **plans** don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments, or other expenses toward this limit.

Physician Services

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

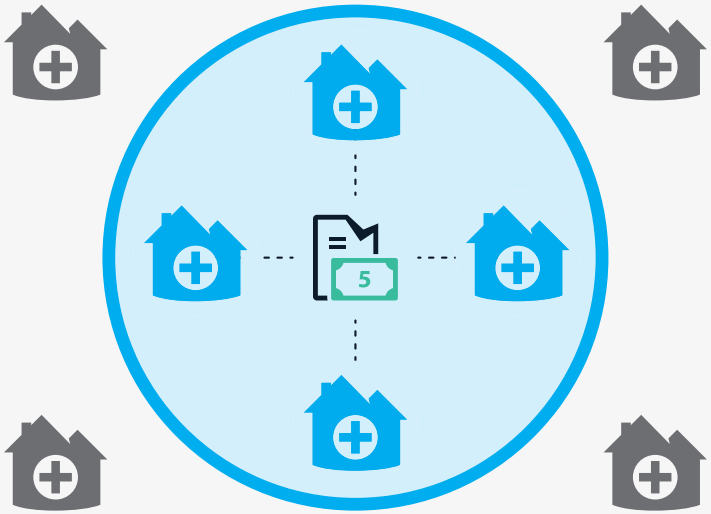
Plan

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 that a health care service, treatment plan, **prescription drug**, or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval, or precertification.

Your **health insurance** 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 to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** has a “tiered” **network** and you must pay extra to see some providers.

Your health insurance may have preferred providers who are also “participating” providers. Participating providers also contract with your health insurer, but the discount may not be as great, and you may have to pay more.

Preferred Provider Organization (PPO)

A PPO is a type of **health insurance** arrangement that allows **plan** participants relative freedom to choose the doctors and hospitals they want to visit.

Premium

The amount that must be paid for your **health insurance**. You and/or your employer usually pay it monthly, quarterly, or yearly.

Prescription Drug Coverage

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

Prescription Drugs

Drugs and medications that by law require a prescription.

See **Prescription Drug Terms Index** for additional definitions.

Preventive Services

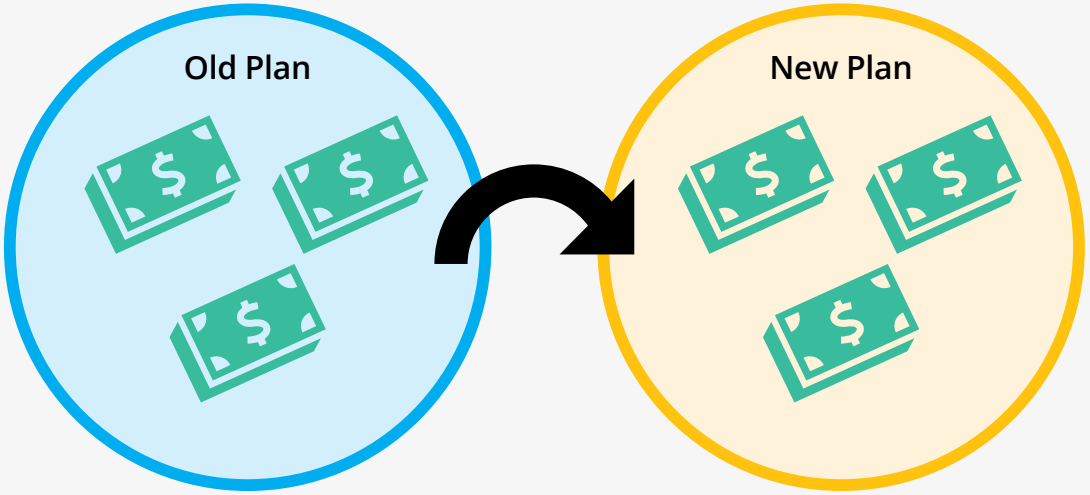
Routine health care that includes check-ups, patient counseling, and screenings to prevent illness, disease, and other health-related problems.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider

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.



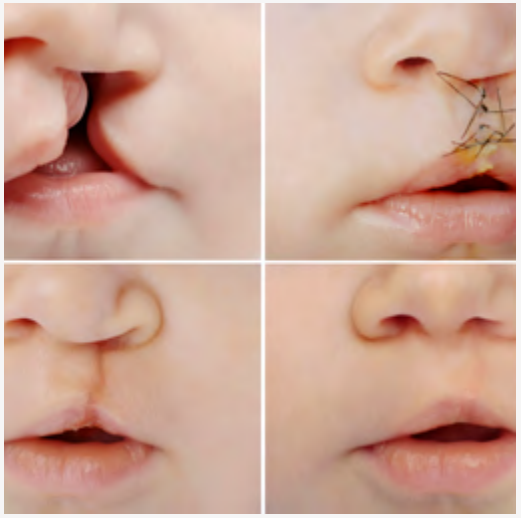
Prior Deductible Credit

During the current calendar year, credit will be given for any amounts applied toward the **deductible** under your prior group health insurance carrier's plan.

If you met all or a portion of your deductible with your prior carrier, you may receive credit for that amount on your new **plan**.

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

A referral is a special kind of pre-approval that individual health plan members — primarily those with **HMOs** — must obtain from their chosen **primary care physician** before seeing a **specialist** or another doctor within the same network.

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.

Summary of Benefits and Coverage (SBC)

An easy-to-read summary that lets you make “apples-to-apples” comparisons of costs and coverage between health plans.

UCR (Usual, Customary, and Reasonable)

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 sometimes is 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**.

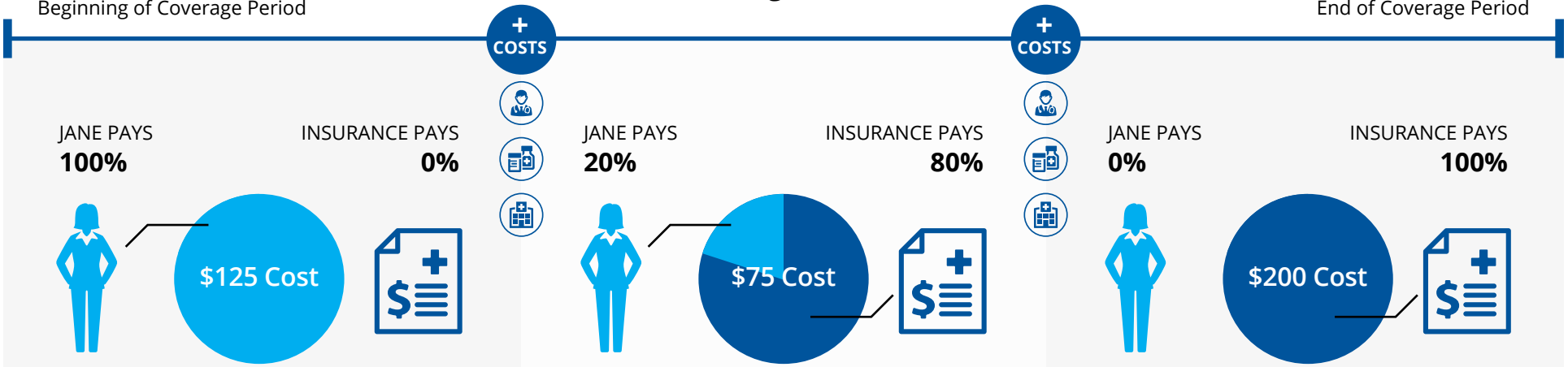
How You and Your Insurer Share Costs Over the Course of Your Coverage Period

Jane's Plan Deductible: $1,500 **Co-Insurance**: 20% **Out-of-Pocket Limit**: $5,000

January 1st
Beginning of Coverage Period

Coverage Period

December 31st
End of Coverage Period



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125

Jane pays: $125

Her plan pays: $0

Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75

Jane pays: 20% of $75, which is $15

Her plan pays: 80% of $75, which is $60

Jane reaches her $5,000 out-of-pocket limit

Jane has seen a doctor often and paid $5,000 in total. Her plan will now pay the full cost of her covered health care services for the rest of the year.

Office visit costs: $200

Jane pays: $0

Her plan pays: $200

Prescription Drug Terms Index

Generic

A generic drug is a pharmaceutical drug that is equivalent to a brand-name product in dosage, strength, route of administration, quality, performance, and intended use.

In most cases, generic products become available after the patent protections afforded to a drug's original developer expire.

Brand

Brand drug that has a trade name and is protected by a patent (can be produced and sold only by the company holding the patent).

Formulary List

A drug formulary is a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value.

A committee of physicians, nurse practitioners, and pharmacists maintain the formulary.

Non-Formulary Drugs

Non-formulary prescriptions aren't on the insurance policy's list of preferred drugs. Non-formularies are more costly.

Specialty Drugs

Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis.

Specialty drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion).

Retail Pharmacy

A pharmacy in which drugs are sold to patients, as opposed to a hospital pharmacy.

Mail Order

An online pharmacy, Internet pharmacy, or mail-order pharmacy is a pharmacy that operates over the Internet and sends the orders to customers through the mail or shipping companies.

Tier 1, 2, 3, 4 Drugs

Tiers 1, 2, 3, and 4 drugs listed on the summary of benefits. Drugs on a formulary are typically grouped into tiers.

The tier that your medication is in determines your portion of the drug cost. A typical drug benefit includes three or four tiers:

- **Tier 1** usually includes generic medications.
- **Tier 2** usually includes preferred brand name medications.
- **Tier 3** usually includes non-preferred brand name medications.
- **Tier 4** usually includes specialty medications (3-Tier programs do not have a unique tier for specialty medications)

A medication may be placed in tier 3 or 4 if it is new and not yet proven to be safe or effective; or there is a similar drug on a lower tier of the formulary that may provide you with the same benefit at a lower cost.

Note: If you have a federally qualified High Deductible Health Plan, you do not have a tiered drug benefit – your pharmacy and medical expenses are subject to your deductible and coinsurance. This section does not apply to you. Sometimes, the active ingredients in a generic drug are chemically identical to their brand name counterparts. When the FDA-approved generic is available, a health plan may limit coverage to the generic, and a pharmacist will dispense the generic medication.

Return to **Prescription Drugs** on page 18