

MCHO Informational Series

Glossary of Health Insurance & Medical Terminology

How to use this glossary

This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions 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. **Bold green** text indicates a term defined elsewhere in this Glossary.

Affordable Care Act. Enacted in March 2010, the federal Patient Protection and Affordable Care Act, commonly referred to as "Obamacare," provides the framework, policies, regulations and guidelines for implementation of comprehensive health care reform by the states. The Affordable Care Act will expand access to high-quality affordable insurance and health care.

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 Patient Services. Medical care provided without need of admission to a health care facility. This includes a range of medical procedures and treatments such as such as blood tests, X-rays, vaccinations, nebulizing and even monthly well-baby checkups by pediatricians.

Appeal. A request for your health insurer or plan 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.

Coinsurance. 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 coinsurance 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 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.

Copayment. 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.

Cost-sharing. The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes **deductibles**,

Summary of Health Insurance Copays, Deductibles, Coinsurance and Maximums

You pay **copays** when you see the doctor or get generic medications. **Deductibles** are the portion you must pay before your insurance begins paying its share. **Coinsurance** is how you and your insurance company share the costs of your care after the deductible is met. Maximum **out-of-pocket** is the largest amount you will pay for treatment in one year.



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coinsurance and **copayments**, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of noncovered services. Cost-sharing in Medicaid and Children's Health Insurance Program also includes premiums.

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 \$1000, your plan won't pay anything until you've met your \$1000 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.

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.

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

Essential Health Benefits. Health care service categories that must be covered by certain plans, starting in 2014. These service categories include ambulatory patient services, **emergency services**, hospitalization, maternity and newborn care, mental health and substance use disorder services, behavioral health treatment, prescription drugs, rehabilitative and **habilitation services** and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care. Insurance policies must cover these benefits in order to be certified and offered in the marketplace, and all Medicaid state plans must cover these services by 2014.

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

Formulary. A formulary is a list of prescription drugs that are covered by a specific health care plan. A formulary can contain both name-brand and generic drugs.

Grievance. A complaint that you communicate to your health insurer 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.

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

In-network Copayment. A fixed amount (for example, \$15) 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**.

Maximum Out-of-Pocket. Your policy may show a maximum amount that you have to pay each year before the insurance company pays everything. If your plan has a \$500 **deductible** with 80/20 to \$10,000, your maximum out-of-pocket expense would be \$2,500 for the year. To arrive at that figure, take 20 percent of \$10,000 (\$2,000) and add the \$500 deductible, which is paid before the coinsurance applies. If the policy covers more than one person, there are two different maximums. One is per individual and the other covers all family members for the year. If you use a doctor or service not in the network of physicians, the maximum out-of-pocket is normally a higher amount.

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 or plan has contracted with to provide health care services.

Open Enrollment. A designated period of time each year — usually a few months — during which insured individuals or employees can make changes in health insurance coverage.

Out-of-network Coinsurance. 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 or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

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

Out-of-Network 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 provider out-of-network.

Out-of-Pocket Expenses. See **Maximum Out-of-Pocket**.

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.

Policy. The contract (agreement) between the person buying health insurance and the company providing it, describing specific health care services that will be covered, any coverage limitations and any out-of-pocket costs (copays) that might be required.

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 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.

Pre-existing Medical Condition. Any illness or condition a patient has prior to obtaining insurance. The **Affordable Care Act** has eliminated differential treatment based on pre-existing conditions starting 2014. This means you can't be denied coverage, charged more, or denied treatment based on health status.

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

Prescription Drug Coverage. Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs. Drugs and medications that by law require a prescription.

Primary Care Physician or Primary Care Provider (PCP). A physician (MD or DO), 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.

Qualified Health Plan. An insurance product that is certified by a marketplace, provides **Essential Health Benefits**, follows established limits on **cost-sharing** (like **deductibles**, **copayments** and out-of-pocket maximum amounts) and meets other requirements.

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.

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.

Special Enrollment. The opportunity for people who experience a life-changing event, such as the loss of a job, death of a spouse or birth of a child, to sign up immediately in an employer's health plan, even if it is outside of the plan's specified enrollment period.

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.

Subsidy. Starting in 2014, **cost-sharing** subsidies and **tax credits** will lower the cost of premiums and out-of-pocket expenses for health coverage that qualifying families purchase through www.healthcare.gov.

Tax Credit. One of the largest **subsidy** programs for health insurance, starting in 2014, to help consumers pay health insurance **premiums**. Tax credits will also be available to small businesses with no more than 25 full-time equivalent employees to help offset the cost of providing coverage.

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

Value-Based Insurance Design (VBID). Encourages effective medical treatments & removes barriers. Targets Asthma, Diabetes, Hypertension & Chronic Obstructive Lung Disease (COPD)

- Reduces barriers to high value care for targeted conditions
- Office visits: primary care, specialists
- Tobacco cessation, weight management, nutrition
- Depression and substance abuse screening
- Prescriptions
- Laboratory & diagnostic screenings

Commonly Used Acronyms

ACA: Affordable Care Act

CHIP: Children's Health Insurance Program

CMS: Center for Medicare & Medicaid Services

EHB: Essential Health Benefits

FFM: Federally Facilitated Marketplace

IHS: Indian Health Service

MAGI: Modified Adjusted Gross Income

PHI: Protected Health Information

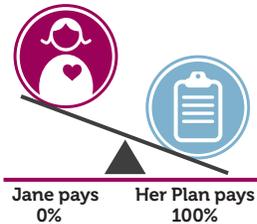
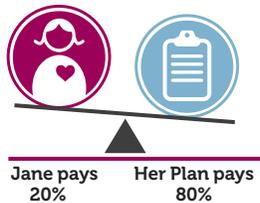
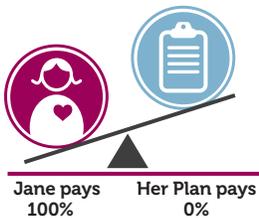
QHP: Quality Health Plan

SHOP: Small Business Health Options Program

How Do Deductibles, Copays, Coinsurances and Maximums Work?

EXAMPLE ▶ Jane's Plan Deductible: \$1500
Co-Insurance: 20%
Out-of-Pocket Limit: \$5000

January 1st Beginning of Coverage Period December 31st
End of Coverage Period



Jane hasn't reached her **Deductible** yet. She pays a set co-pay for some Provider visits and medications. Jane pays 100% for other costs, such as lab work or out-patient services.



Jane reaches her \$1500 **Deductible**, 20% **co-insurance** begins. She still pays a set co-pay for some Provider visits and medications. For other health care costs, Jane now pays 20%, and her insurer pays 80%.



Jane reaches her \$5000 **out-of-pocket limit**. Jane has seen her providers often and had some surgery. She has paid \$5000 on her OOP total. Her Plan now pays 100% of all covered costs for the rest of the year, including office visits and medications.

Source: U.S. Department of Labor, 2013. <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf>