Glossary of Health Insurance & Medical Terms

My Benefit Advisor has put together this glossary of common terms for human resource professionals, benefits specialists, employers, employees and individuals to help navigate the complexities of health insurance. Remember, some of these terms may have different meanings depending on the plan or health insurance policy. Use this glossary as a guide or reference. The policy or plan governs the meaning.

Allowed Amount
The maximum payment the plan will reimburse for a covered health care service. Sometimes called: *eligible expense, payment allowance*, or *negotiated rate*.

Appeal
A request that the health insurer or plan review a decision that denies a benefit or payment, either in whole or in part.

Assignment of Benefits (AOB)
A legal document that transfers a patient's health insurance benefit to their healthcare provider enabling the provider to receive payment directly from the insurance company.

Balance Billing
This occurs when a provider bills the patient for the balance remaining on the bill. This amount is the difference between the actual billed amount and the allowed amount paid by the insurer. For example, if the health care provider charges $200 for a service and the allowed amount is $100, the provider may bill $100 for the remaining amount owed. In most cases, this occurs when an out-of-network provider (non-preferred provider) is used. A network provider (preferred provider) has accepted the allowed amount and cannot balance bill.

Claim
A request for a benefit (including reimbursement of a health care expense) made by the patient or health care provider for items or services that may or may not be covered.

Coinsurance
The patient's share of costs for a covered health care service, calculated as a percentage (for example: 20%) of the allowed amount for the service. The patient is responsible for coinsurance and any deductible owed. For example, if the health insurance or plan's allowed amount for an office visit is $100, and the deductible is satisfied, the coinsurance would be 20% of $100 or $20. The health insurance or plan pays the rest of the allowed amount, $80 in this example.

Complications of Pregnancy
Conditions due to pregnancy, labor, and/or delivery that require medical care to prevent serious harm to the health of the mother or fetus. Morning sickness and non-emergency caesarean section are generally not considered complications of pregnancy.

Copayment
A fixed amount paid for a covered health care service (for example: $20) that is usually paid at the time of service. Sometimes called a "copay", the amount can vary by the type of covered service.

Cost-Sharing
The patient's share of costs for service that a plan covers, also known as *out-of-pocket costs*. Examples of cost-sharing are copayments, deductibles, and coinsurance. Family cost-sharing refers to the share of costs for deductibles and other out-of-pocket costs that the main insured and covered family members (spouse and/or children) must pay out-of-pocket. Other costs including premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually are not considered cost-sharing.

Cost-Sharing Reductions
These are discounts that reduce the amount payable for certain services covered by an individual plan purchased through the Marketplace (see Marketplace). A discount may apply if the patient's income is below a specified level and the insured chooses a Silver level health plan, or is a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible
An amount an insured could owe during a coverage period (usually one year) for covered health care services before the plan begins to pay. An overall deductible applies to all or almost all covered items and services.

- Some overall deductible plans may also have separate deductibles that apply to specific services or groups of services
- Other plans may have only separate deductible. For example if the deductible is $1,000, the plan won't pay anything until that $1,000 deductible has been met for covered health services subject to the deductible.

Diagnostic Test
Tests to discover what the health problem is or rule out other conditions. For example, an x-ray is a diagnostic test that could be used to discover a broken bone.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Examples of DME: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition
An illness, injury, symptom (including severe pain), or condition severe enough to endanger the patient's health if not treated right away. Failure to receive medical attention could reasonably result in 1) serious danger to the patient's health; 2) serious problems with bodily functions; or 3) serious damage to any part or organ of the patient's body.

Emergency Medical Transportation
Ambulance service for an emergency medical condition. These may include transportation by air, land, or sea. Not all plans cover all types of emergency medical transportation or may pay less for certain types.

Emergency Room Care / Emergency Services
Services to check for and treat an emergency medical condition. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Exclusive Provider Organization (EPO)
An Exclusive Provider Organization is a type of managed care plan where non-emergency services are covered only if the insured goes to doctors, specialists, or hospitals in the plan's network.

Excluded Services
Health care services that a plan does not pay for or cover.

Explanation of Benefits (EOB)
An EOB is a written description of how an insurer calculated benefits of a health insurance claim. An EOB is sent to the patient or provider and helps:

- Track out-of-pocket expenses
- See the balance of a deductible and out-of-pocket limit
- Ensure the patient is only being charged for services received
- Check that information is correct

Formulary
A list of drugs covered under a plan. A formulary may include the insured's share of the cost for each drug. The plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and a different cost-sharing amount will apply to each tier.

Grievance
A complaint to be communicated to the health insurer or plan.

Habilitation Services
Health care services that help an insured keep, learn, or improve skills and functionality for daily living. Some examples include physical and occupational therapy, speech language pathology and other inpatient or outpatient services for people with disabilities, and therapy for a child who is not walking or talking at the normal rate.

Health Insurance
A contract that requires a health insurer to pay some or all health care costs in exchange for a premium. A health insurance contract may also be called a *policy* or *plan*.

Health Maintenance Organization (HMO)
A type of health insurance plan that generally limits coverage to care from contracted physicians, hospitals, and other providers in exchange for lower out-of-pocket costs and premiums. HMOs cover emergency care regardless of the health care provider's contracted status. An HMO may require the insured live or work in its service area. HMOs are known for integrated focus on prevention and wellness.

Home Health Care
Health care services and supplies delivered in home under a doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually does not include help with non-medical tasks, such as cooking, cleaning, and driving.

Hospice Services
A comprehensive program that provides comfort and support for people in the final stages of a terminal illness and their families. Focus is on improving quality of life and managing symptoms, rather than curing the condition.

Hospitalization or Hospital Stay
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care.

Hospital Outpatient Care
Care in a hospital that usually does not require an overnight stay.

In-Network Copayment
A fixed amount paid for covered health care services to a provider who contracts with a health insurance plan, for example, $15 per visit. In-network copayments are usually less than out-of-network copayments.

Marketplace
A Marketplace for health insurance where individuals, families and small businesses can:

- Learn about their plan options
- Compare plans based on costs, benefits, and other important features
- Apply for and receive financial help with premiums and cost sharing based on income
- Choose a plan and enroll in coverage

Also known as an "Exchange", the Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP).

Maximum Out-of-Pocket
In most plans or health insurance, this is the highest amount an insured individual or family can be required to pay for covered medical costs during a plan year before the health insurance plan begins covering 100% of the cost for the rest of the year. This amount may be higher than the out-of-pocket limits stated in the plan or policy.

Medically Necessary
Care within accepted standards of medicine, these are health care services and supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms.

Minimum Essential Coverage (MEC)
This describes a certain type of health insurance that meets the Marketplace / Affordable Care Act (ACA) requirement for health insurance. Individuals who don't have MEC and are not exempt from the requirement may be required to pay a penalty when filing taxes. Some examples of MEC:

- Employer-sponsored plans, including COBRA and retiree coverage
- Health plans purchased through the Health Insurance Marketplace
- Medicare Part A and Medicare Advantage plans
- Most Medicaid coverage
- Children's Health Insurance Program (CHIP)
- Some types of veterans health coverage
- TRICARE
- Coverage provided to Peace Corp volunteers.

Coverage that provides only dental or vision, or that only discount health care services, do not qualify as MEC.

Minimum Value Standard
The minimum value standard is a basic level of health insurance provided by an employer. The plan meets the standard if it covers at least 60% of the total allowed costs of benefits. The plan must also offer substantial coverage of hospital and doctor services. If an employer plan meets the minimum value standard and is considered affordable, individuals will not qualify for a premium tax credit to purchase coverage in the Marketplace.

Network
A network is comprised of the facilities, providers, and suppliers a health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider or Participating Provider)
Providers that have contracted with a health insurer or plan. These providers have agreed to provide services to participants in a plan. The insured will generally pay less for services when using a network provider.

Orthotics and Prosthetics
Devices to supplement or replace body components that have been damaged or deformed due to illness, injury, or other conditions. These include leg, neck and arm braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. Services also include fitting, adjustment, repairs, and replacements due to wear, loss, or changes in the patient's condition.

Out-of-Network Coinsurance
The insured's share (for example, 40%) of the allowed amount for a covered health care service paid to providers who are not contracted with the insured's health insurance or plan. Out-of-network coinsurance usually costs more than in-network coinsurance.

Out-of-Network Copayment
A fixed amount (for example, $30) an insured must pay for covered health care services from a provider who does not contract with their health insurance or plan. Out-of-network copayments usually costs more than in-network copayments.

Out-of-Network Provider (Non-Preferred Provider)
A provider (also referred to as non-preferred or non-participating provider) that does not have a contract with the insured's health plan. Many plans cover out-of-network services but the insured usually pays more. The plan or policy will explain those costs.

Out-of-Pocket Limit
The cost paid by the insured during a coverage period (usually one year) for their share of covered services. Once the limit is met, the plan will usually pay 100% of the allowed amount. While helping to anticipate costs, the limit never includes the cost of premiums, balanced-billed charges, or services not covered under the plan. Some plans do not count all copayments, deductibles, coinsurance payments, out-of-pocket network payments, or other expenses when calculating this limit.

Palliative Care
Specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness.

Physician Services Health Care
Services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan
Health insurance coverage issued directly as an individual or through an employer, union, or other group sponsor in a group plan. Also called *health insurance plan, policy, health insurance policy,* or *health insurance*.

Point of Service (POS)
This type of insurance plan utilizes a network of doctors, hospitals, and other health care providers, in exchange for lower out-of-pocket costs. POS plans require you to get a referral from your primary care physician to see a specialist.

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*. An insurer may require preauthorization for certain services before they are performed, except in an emergency. Preauthorization does not guarantee the plan will cover the cost.

Preferred Provider Organization (PPO)
A type of health plan that contracts with medical providers, such as doctors, specialists, and hospitals, to form a network of participating providers. Insureds are often called members and pay less if they use providers that belong in the plan's network. Members will pay more if they choose doctors, hospitals, and providers outside the network.

Premium
The amount that must be paid by the individual or employer to have coverage under a health insurance plan.

Premium Tax Credits
Financial help available when health insurance is obtained through the Marketplace and the insured's income is below a certain level. These credits offset the cost of obtaining private health insurance for an individual or family. Advance payments of the tax credit can be used immediately to lower monthly premium costs.

Prescription Drug Coverage
Coverage under a plan that helps pay for prescription drugs. See also *Formulary*.

Preventive Care (Preventive Service)
Routine health care including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health conditions.

Primary Care Physician
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services.

Primary Care Provider
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps the patient access a range of health care services.

Provider
An individual or facility that provides health care services. Examples include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be 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 written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you must get a referral before you can get health care services from anyone except your primary care provider. Without a referral first, the plan may not pay for the services.

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 occupation therapy, speech-language pathology, and/or psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, often performed absent of symptoms, signs, or prevailing medical history.

Skilled Nursing Care
Service performed or supervised by licensed nurses in the home or a nursing home. Skilled nursing care is not the same as *skilled care services,* which are services performed by therapists and technicians in the home or nursing home.

Specialist
A doctor or health professional who is trained and licensed to practice in a particular area of medicine. Examples include oncologist (cancer), dermatologist (skin), hematologist (blood), neurologist (nervous system), and orthopedist (bones or muscle).

Specialty Drug
Often the most expensive drugs on a formulary, these are prescription drugs that, in general, require special handling or ongoing monitoring and assessment by a health care professional, or are somewhat difficult to dispense.

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 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 severe enough to warrant emergency room care.

For more information about My Benefit Advisor or to contact a representative, visit us online at www.mybenefitadvisor.com