Glossary of Health Coverage and Medical Terms

- This glossary defines 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, Summary Plan Description (SPD) or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real-life situation.

**Allowed Amount**
This is the maximum payment the plan will pay for a covered healthcare service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

**Appeal**
A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

**Balance Billing**
When a provider bills you for the balance remaining on the bill that your plan doesn’t cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider’s charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

**Claim**
A request for a benefit (including reimbursement of a healthcare expense) made by you or your healthcare provider to your health insurer or plan for items or services you think are covered.

**Co-insurance**
Your share of the costs of a covered healthcare service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally 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 20% would be $20. 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 caesarean section generally aren’t complications of pregnancy.

**Co-payment**
A fixed amount (for example, $15) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

**Cost Sharing**
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are co-payments, deductibles and co-insurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay or the cost of care a plan doesn’t cover, usually aren’t considered cost sharing.

**Cost-sharing Reductions**
Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver-level health plan or if you’re a member of a federally recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.
**Deductible**
An amount you could owe during a coverage period (usually one year) for covered healthcare services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered healthcare services subject to the deductible.)

**Diagnostic Test**
Tests to figure out what your health problem is. For example, an X-ray can be a diagnostic test to see if you have a broken bone.

**Durable Medical Equipment (DME)**
Equipment and supplies ordered by a healthcare provider for everyday or extended use. DME may include oxygen equipment, wheelchairs and crutches.

**Emergency Medical Condition**
An illness, injury, symptom (including severe pain) or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention, you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

**Emergency Medical Transportation**
Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

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

**Excluded Services**
Healthcare services that your plan doesn't pay for or cover.

**Formulary**
A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your 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 different cost-sharing amounts will apply to each tier.

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

**Habilitation Services**
Healthcare 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 a health insurer to pay some or all of your healthcare costs in exchange for a premium. A health insurance contract may also be called a “policy” or “plan.”

**Home Health Care**
Healthcare services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers or other licensed healthcare providers. Home health care usually doesn’t include help with non-medical tasks, such as cooking, cleaning or driving.

**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. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

**Hospital Outpatient Care**
Care in a hospital that usually doesn't require an overnight stay.
Individual Responsibility Requirement
Sometimes called the “individual mandate,” the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don’t have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Co-insurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

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

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; and 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 also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone and in-person.

Maximum Out-of-Pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Healthcare services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace, or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you’re offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes and external breast prostheses after a mastectomy. These services include adjustment, repairs and replacements required because of breakage, wear, loss or a change in the patient’s physical condition.

Out-of-Network Co-insurance
Your share (for example, 40%) of the allowed amount for covered healthcare services to providers who don’t contract with your health insurance or plan. 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 healthcare services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.
Out-of-Network Provider
(Non-preferred Provider)
A provider who doesn’t have a contract with your plan to provide services. If your plan covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider.”

Out-of-Pocket Limit
The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for healthcare costs. This limit never includes your premium, balance-billed charges or healthcare your plan doesn’t cover. Some 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
Healthcare services a licensed medical physician, including an MD (Medical Doctor) or DO (Doctor of Osteopathic Medicine), provides or coordinates.

Plan
Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain healthcare costs. Also called “health insurance plan,” “policy,” “health insurance policy” or “health insurance.”

Preauthorization
A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment (DME) 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.

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.

Premium Tax Credits
Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage
Coverage under a plan that helps pay for prescription drugs. If the plan’s formulary uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you’ll pay in cost sharing will be different for each “tier” of covered prescription drugs.

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

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

Primary Care Physician
A physician, including an MD (Medical Doctor) or DO (Doctor of Osteopathic Medicine), who provides or coordinates a range of healthcare services for you.

Primary Care Provider
A physician, including an MD (Medical Doctor) or DO (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 you access a range of healthcare services.

Provider
An individual or facility that provides healthcare services. Some examples of a provider 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 healthcare services. In many health maintenance organizations (HMOs), you need to get a referral before you can get healthcare services from anyone except your primary care provider. If you don’t get a referral first, the plan may not pay for the services.

Rehabilitation Services
Healthcare 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.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as “skilled care services,” which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a healthcare professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

Summary Plan Description (SPD)
The plan document, which describes what benefits the plan provides and how it operates. It provides information on when an employee can begin to participate in the plan, how to enroll dependents and how to file a claim for benefits.

Taft-Hartley Trust Fund
A collectively bargained, self-funded, employee benefit plan maintained by more than one employer, usually within the same or related industries, and a labor union.

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.
Jane's Plan

Deductible: $1,500
Co-insurance: 20%
Out-of-Pocket Limit: $5,000

January 1st
Beginning 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, reaching her deductible. So her plan pays some of the costs for her next visit.
Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered healthcare services for the rest of the year.
Office visit costs: $125
Jane pays: $0
Her plan pays: $125