

GLOSSARY OF MEDICAL AND INSURANCE TERMS

At Westfield Family Physicians we are aware that there are lots of words and phrases we used every day that may not be familiar to you, our patients. We are providing this glossary to help you make sense of the healthcare industry so that you know better:

1. how medical insurance works
 2. what you are financially responsible for with respect to your care, and
 3. how you can be a more informed healthcare consumer.
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Ancillary Services

Services, other than those provided by a physician or hospital, which are related to a patient's care, such as laboratory work, x-rays and anesthesia.

Appeal

Request made to a payer to reconsider a decision, such as a claim denial or denied prior authorization request. Most appeals must be submitted in writing within a specified period.

Beneficiary

A person eligible for benefit under a health insurance policy.

Benefit

Amount payable by the insurance company to a claimant, assignee, or beneficiary when the insured suffers a loss.

Care Plan

A written plan for one's health care. Our healthcare providers sometimes provide a care plan to help you to better care for your healthcare needs between office visits, and gauge your progress.

Case Management

A process whereby an insured person with specific health care needs is identified and a plan which efficiently utilizes health care resources is designed and implemented to achieve the optimum patient outcome in the most cost-effective manner.

Claim

Form submitted to a payer (by a healthcare provider or patient) to request payment for items or services.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA, requires group health plans with 20 or more employees to offer continued health coverage for employees and their dependents for 18 months after the employee leaves the job. Longer durations of continuance are available under certain circumstances. If a former employee opts to continue coverage under COBRA, the former employee must pay the entire premium, plus a 2% administration charge.

Co-insurance

Cost-sharing arrangement between an insured person and the health insurance company in which the insured person is required to pay a percentage of the cost for the health care services received. Coinsurance typically applies after satisfaction of a deductible. For example, 80% coinsurance may apply after a \$500 deductible has been satisfied.

Coordination of Benefits (COB)

A provision in the contract that applies when a person is covered under more than one health insurance plan. It requires that payment of benefits be coordinated by all plans to eliminate over-insurance or duplication of benefits. An example of this may be when two married individuals each have a separate health insurance policy through an employer, and one has spousal coverage. Each plan will have rules about how the benefits will be coordinated, including which plan is primary and which plan is secondary when it comes to paying on a claim.

Co-payment (Co-pay)

Co-payment is a predetermined fee, in addition to what health insurance covers, that an individual pays for health care services. For example, a health plan may require a \$20 co-pay for normal services delivered during a physician office visit.

Cost Sharing

This occurs when the users of a health care plan share in the cost of medical care. Deductibles, coinsurance, and co-payments are examples of cost sharing.

Covered Person

An individual who meets eligibility requirements and for whom premium payments are paid for specified benefits of the contractual agreement.

Deductible

A cost-sharing arrangement between an insured person and health insurance company in which the insured person is required to pay a fixed dollar amount of covered expenses each year before the health insurance company will reimburse for covered health care expenses. Generally, an insured person is responsible for a deductible each calendar year. For example, if your policy has a \$1,000 annual deductible, you will be responsible for paying the first \$1,000 of medical costs each year before the health insurance company begins paying those costs.

Durable Medical Equipment (DME)

Equipment that is to be used in a patient's home or living facility. DME may include items such as oxygen, hospital beds, wheelchairs, canes, potty chairs, etc.

Effective Date

The date health insurance coverage begins.

Enrollee

The person who is the primary insured. Under an individual or family policy, this person is the applicant. Under an employer-sponsored group health policy, this person is the employee.

Exclusions and Limitations

Medical services that are either not covered or limited in benefit by a health insurance policy.

Explanation of Benefits (EOB)

Statement sent by health plans to persons who have experienced a claim under the health plan. The explanation of benefits (EOB) details the charges for the services received, the amount the health insurance company will pay for those services, and the amount the insured person will be responsible for paying.

Fee-for-Service

A payment system for health care where the provider is paid for each service rendered rather than a pre-negotiated amount for each patient.

Fee Schedule

A complete listing of fees used by health plans to pay doctors or other providers.

Flexible Spending Account (FSA)

An employee benefits cash account from which non-taxable withdraws can be made to fund eligible expenses defined by the employer-sponsored plan. The FSA is funded by reductions in salary prior to calculation of federal income and social security taxes.

Formulary

A list of certain drugs and their proper dosages. Under most health plans, better benefits are provided for formulary drugs than are provided for non-formulary drugs.

Group Health Plan

A health plan that provides health coverage to employees and their families, and is supported by an employer or employee organization.

Healthcare Provider

A doctor, hospital, laboratory, nurse, or anyone who delivers medical or health-related care. In our office, we have three types of healthcare providers: physicians, physician assistants and nurse practitioners.

Health Maintenance Organization (HMO)

Prepaid health plans which cover doctors' visits, hospital stays, emergency care, surgery, preventive care, checkups, lab tests, X-rays, and therapy. In a HMO, one must choose a primary care physician (or PCP) who coordinates all care and makes referrals to any specialists that may be required. In a HMO, one must use the doctors, hospitals and clinics that participate in your plan's network. No benefits are paid for non-emergency benefits provided outside the HMO network.

Health Reimbursement Arrangement (HRA)

A tax-advantaged employee health spending account funded and owned by the employer. Funds remaining in the account at year-end revert to the employer. For the employee, HRAs are a "use it or lose it" proposition.

Health Savings Account (HSA)

Operating similarly to IRAs, HSAs are tax-advantaged savings accounts for health care services. A person must enroll in a qualified High-Deductible Health Plan (HDHP) before they can establish an HSA.

High Deductible Health Plan (HDHP)

A person must be enrolled in a qualified High-Deductible Health Plan (HDHP) before they can establish a Health Savings Account (HSA). Not all high-deductible health plans qualify for purposes of establishing HSA eligibility. A qualified HDHP benefit design must conform to various federally-mandated requirements.

Independent Practice Associations (IPA)

An IPA is a type of HMO in which care is provided by independent physicians who contract with the HMO. This contrasts with the "staff model" HMO, in physicians are employees of the HMO.

Inpatient Care

Health care that you get when you stay overnight in a hospital.

Insured

A person who has obtained health insurance coverage under a health insurance plan.

Managed Care

An organized way to manage costs, use, and quality of the health care system. The major types of managed care plans are health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Medicaid

Federal and state health insurance program for low-income individuals who meet established eligibility criteria (programs vary from state to state).

Medical Necessity

Medical information justifying that the service rendered or item provided is reasonable and appropriate for the diagnosis or treatment of a medical condition or illness.

Medicare

Federal health insurance program for the elderly (age 65 and older), certain disabled individuals, and those with end-stage renal disease. Medicare is administered by the Center for Medicare and Medicaid Services (CMS).

Medicare Supplement

A supplemental insurance policy to help cover the difference between approved medical charges and benefits paid by Medicare. These plans are also known as "Medi-gap" plans.

Medically Necessary

Many insurance policies will pay only for treatment that is deemed "medically necessary" to restore a person's health. For instance, many health insurance policies will not cover routine physical exams or plastic surgery for cosmetic purposes.

Medigap

A supplemental insurance policy to help cover the difference between approved medical charges and benefits paid by Medicare. These plans are also known as "Medicare Supplement" plans.

National Committee for Quality Assurance (NCQA)

A national group responsible for devising and monitoring quality measurements and standards for health care entities.

Network Provider

Physicians, hospitals or other providers of medical services that have agreed to participate in a network, to offer their services at negotiated rates, and to meet other negotiated contractual provisions. Also called "participating provider."

Open Enrollment

A period each year during which employees have an opportunity to change their employer-provided health care coverage. They usually can choose among various plans from different health insurance providers.

Out-Of-Network

Health care services received outside the HMO or PPO network.

Out-of-Pocket Costs

Insured health care costs for which one is responsible, because of the application of deductibles, coinsurance and co-payments.

Out-of-pocket maximum

Total dollar amount an insured will be required to pay for covered medical services during a specified period, such as one year. The out-of-pocket maximum may also be called the stop-loss limit or catastrophic expense limit.

Outpatient Care

Health care that you get when you visit a doctor's office, clinic, or diagnostic center which does not involve an overnight stay.

Participating Provider

A health care provider who has been contracted to render medical services or supplies to insured persons at a pre-negotiated fee. Providers include hospitals, physicians, and other medical facilities that are part of a PPO or HMO network.

Policy

The insurance agreement or contract.

Policy Year

The twelve month period beginning with the effective date or renewal date of the policy.

Policyholder

The insured person named on the insurance policy.

Pre-Authorization

Under a pre-authorization provision of a health insurance policy, the insured must contact the health insurance company prior to a hospitalization or surgery, and receive authorization for the service.

Pre-Certification

This is a requirement that a insured person call their health insurance company and advise them a doctor has stated certain medical treatment is required. This is done before receiving treatment from the doctor or hospital. A health insurance policy will normally list the medical conditions that require pre-certification before receiving treatment. When pre-certification is not received, benefits will be reduced or possibly not covered.

Pre-existing Condition

A health problem that existed before the date your insurance became effective. Each health insurance company uses its own particular definitions of pre-existing condition. However, the following statement is in line with most insurance company provisions: "A pre-existing condition is a medical condition that would cause a normally prudent person to seek treatment during the twelve months prior to the beginning of coverage."

Preferred Provider Organization (PPO)

A network of health care providers with which a health insurer has negotiated contracts for its insured population to receive health services at discounted costs. Health care decisions generally remain with the patient as he or she selects providers and determines his or her own need for services. Patients have financial incentives to select providers within the PPO network.

Premium

The amount you or your employer pays in exchange for health insurance coverage.

Prescription coverage (Rx coverage)

The part of your insurance that covers your prescriptions or medications.

Preventive Care

An approach to health care which emphasizes preventive measures and health screenings such as routine physicals, well-baby care, immunizations, diagnostic lab and x-ray tests, pap smears, mammograms and other early detection testing. The purpose of offering coverage for preventive care is to diagnose a problem early, when it is less costly to treat, rather than late in the stage of a disease when it is much more expensive, or too late to treat.

Primary Care Physician (PCP)

Under a health maintenance organization (HMO) plan, the primary care physician is usually an insured person's first contact for health care. This is often a family physician, internist, or pediatrician. A primary care physician monitors patient health, treats most patient health problems, and refers patients, if necessary, to specialists.

Prior authorization

Some health plans require that your physician obtain approval, or authorization, from the plan in order to provide a specific medication or a test for you. Without this prior authorization, your health plan may not pay for your medication or test.

Provider

Any person (doctor or nurse) or institution (hospital, clinic, or laboratory) that provides medical care.

Qualifying Event

An occurrence (such as death, termination of employment, divorce, etc.) that changes an employee's eligibility status under a group health plan. The term is most frequently used in reference to COBRA eligibility.

Reasonable and Customary (R &C) Charge

A term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is generally considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community. "Reasonable and Customary (R&C) Charge" essentially means the same thing as "Usual and Customary (U&C) Charge."

Referral

An OK from the primary care physician for the patient to see a specialist or get certain services. In many HMO plans, the insured person needs to get a referral before they get care from anyone except the primary care physician. If the referral is not received, the HMO may cover resulting expenses.

Risk

For a health insurance company, risk is the chance of loss, the degree of probability of loss or the amount

of possible loss. For an individual, risk represents such probabilities as the likelihood of surgical complications, medications' side effects, exposure to infection, or the chance of suffering a medical problem because of a lifestyle or other choice. For example, an individual increases his or her risk of getting cancer if he or she chooses to smoke cigarettes.

Rx coverage (Prescription coverage)

The part of your insurance that covers your prescriptions or medications.

Self-insured (Self Administered)

The self-insured employer assumes risk for health care expenses in a plan that is self-administered or administered through a contract with a third-party organization. This form of coverage is regulated by the Employee Retirement Income Security Act of 1974. Hence, self-insured health plans fall under federal, rather than state, regulation.

Skilled Nursing Facility

A licensed institution that provides regular medical care and treatment to sick and injured persons. Daily medical records are kept and patients are under the care of a licensed physician.

Staff Model HMO

A type of HMO in which care is provided by physicians who are employees of the HMO. This contrasts with the "independent practice association (IPA)" HMO, in which independent physicians contract with the HMO.

Stop-loss Provisions

A limit in a health insurance policy that provides for 100% payment of expenses after total patient out-of-pocket expenses exceed a certain contractual dollar amount.

Third-Party Payer

Any payer of health care services other than the insured person. This can be an insurance company, HMO, PPO, or the federal government.

Urgent Care

Health care provided in situations of medical duress that have not reached the level of emergency. Claim costs for urgent care services are typically much less than for services delivered in emergency rooms.

Usual and Customary (U&C) Charge

A term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is generally considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community. "Usual and Customary (R&C)" essentially means the same thing as "Reasonable and Customary (R&C) Charge."

Waiting Period

A period of time when the health plan does not cover a person for a particular health problem.

Workers Compensation

Insurance that employers are required to have to cover employees who get sick or injured on the job.