

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](#) 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 such 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.)
- **Bold** text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

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](#).)

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

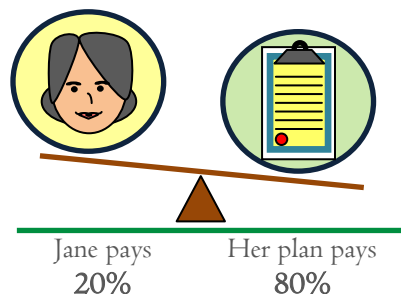
When a [provider](#) bills you for the difference between the provider's charge and the [allowed amount](#). For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A [preferred provider](#) may *not* balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally 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 coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

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.

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

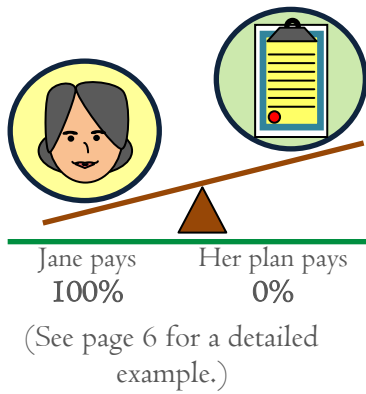
The general term that refers to the share of costs for services covered by a [plan](#) or [health insurance](#) that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of types of cost sharing include [copayments](#), [deductibles](#), and [coinsurance](#). Other costs, including your [premiums](#), penalties you may have to pay or the cost of care not covered by a plan or policy are usually *not* considered cost sharing.

Cost-sharing Reductions

Discounts that lower [cost sharing](#) for certain services covered by individual [health insurance](#) purchased through the [Marketplace](#). You can get these discounts if your income is below a certain level, and you choose a Silver level health [plan](#). If you're a member of a federally recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation, you can qualify for cost-sharing reductions on certain services covered by a Marketplace policy of any metal level and may qualify for additional cost-sharing reductions depending upon income.

Deductible

The amount you *could* owe during a coverage period (usually one year) 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.



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 health care **provider** for everyday or extended use. DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition that is severe enough (including severe pain), that if you did not get immediate medical attention you could reasonably expect one of the following to result: 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** or **health insurance** may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care

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

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

Formulary

A list of drugs your **health insurance** or **plan** covers. A formulary may include how much you pay for each drug. If the plan uses "tiers," the formulary may list which drugs are in which tiers. For example, a formulary may include generic drug and brand name drug tiers.

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**. A health insurance contract may also be referred to as a "policy."

Home Health Care

Health care 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 health care **providers**. Home health care usually does not 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. An overnight stay for observation could be outpatient 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 do not have minimum essential coverage, you may have to make a payment when you file your federal income tax return. You may not have to meet this requirement if no affordable coverage is available to you, or if you have a short gap in coverage during the year for less than three consecutive months, or qualify for a **minimum essential coverage exemption**.

In-network Coinsurance

The percentage (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 copayments usually are less than **out-of-network copayments**.

Marketplace

A resource where individuals, families, and small businesses can learn about their health coverage options; compare **health insurance** plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly **premiums** and out-of-pocket costs of coverage available through the Marketplace (see **premium tax credits** and **cost-sharing reductions**), and information about other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). The Marketplace is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government.

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.

Minimum Essential Coverage

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

Minimum Essential Coverage Exemption

A status that allows you to not have to make a payment for not having **minimum essential coverage**. You must meet certain eligibility requirements to get an exemption. Some exemptions require an application, while others may be available through the federal income tax filing process.

Minimum Value Standard

The Affordable Care Act generally establishes certain value standards for **plans** and **health insurance**. For example, “bronze level” individual insurance is designed to pay about 60% of the total cost of certain essential medical services, on average, for a standard population. Plans are subject to a minimum value standard that is similar to that 60% standard, although the benefits covered by the plan may differ from those covered under individual insurance.

Network

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

Non-Preferred Provider

A **provider** who doesn’t have a contract with your health insurer or **plan** to provide services to you. You’ll generally pay more to see a non-preferred provider than to see a **preferred provider**. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a “tiered” **network** and you must pay extra to see some providers. Your policy may use the term “out-of-network” or “non-participating” instead of “non-preferred.”

Out-of-network Coinsurance

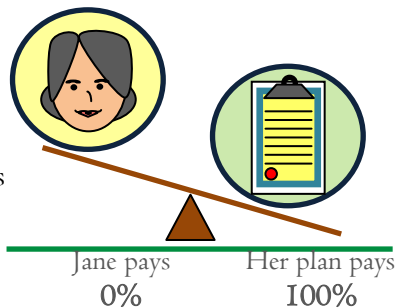
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to **providers** who do **not** contract with your **health insurance** or **plan**. Out-of-network coinsurance usually costs you more than **in-network coinsurance**.

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-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**. (See page 6 for a detailed example.) This limit helps you plan for health care costs. This limit never includes your **premium**, **balance-billed** charges or health care your **health insurance** or **plan** doesn't cover. Some health insurance or plans don't count all of your **copayments**, **deductibles**, **coinsurance** payments, out-of-network payments or other expenses toward this limit.

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

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 or **plan** that a health care 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.

Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your **health insurance** policy or plan document to see if you can see all preferred providers without paying extra or if your health insurance or **plan** has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or **plan** may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or **plan**, but the discount may be smaller, so you may have to pay more. Your policy may use the term "in-network" instead of "preferred."

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

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

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care

Routine health care, including **screenings**, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

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 for you.

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 you access a range of health care services.

Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), other health care professional, hospital, or other health care facility licensed, certified or accredited as required by state law.

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 need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the **plan** or **health insurance** may not pay for the services.

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.

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 physician specialist focusing 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 special training in a specific area of health care.

Specialty Drug

A type of **prescription drug** that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. If the **plan's formulary** uses “tiers,” and specialty drugs are included as a separate tier, you will likely pay more in **cost sharing** for drugs in the specialty drug tier.

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 - Example

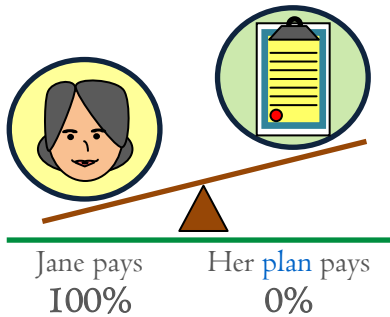
Jane's Plan Deductible: \$1,500

Coinsurance: 20%

Out-of-Pocket Limit: \$5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



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

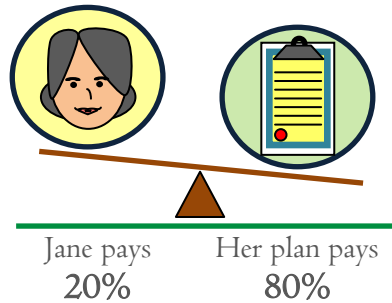
Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0

more costs



Jane reaches her \$1,500 deductible, coinsurance begins

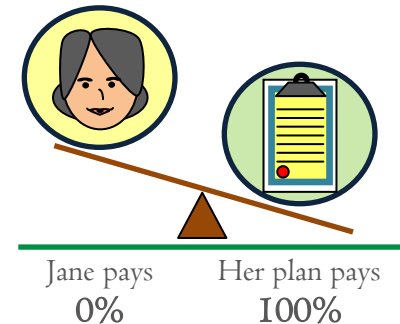
Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: \$75

Jane pays: 20% of \$75 = \$15

Her plan pays: 80% of \$75 = \$60

more costs



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 health care services for the rest of the year.

Office visit costs: \$200

Jane pays: \$0

Her plan pays: \$200