Health Insurance

GLOSSARY & TERMS

What Consumers Should Know About Health Insurance

Term	Definition
Actual Charge	The billing charge of the provider.
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 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.
Co-insurance	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 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.
Community Rating	A method of calculating health plan premiums using the average cost of health services for all subscribers. Under modified community rating, rates may vary based on demographic characteristics.
Co-payment	An amount paid by the health plan member. Could be a fixed amount per service, a percentage of the eligible charge, or in the case of out of network providers it may be the amount in excess of the eligible charge.
Cost-sharing	Health insurance does not pay for everything. A health maintenance organization requires that you pay copayments for certain services, which can be a flat dollar amount or a percentage of the applicable charges. A preferred provider plan requires that you pay a copayment which is a percentage of the amount paid by the health plan to the provider. This percentage is higher for non-participating providers than for participating providers. Also, if you go to a non-participating provider, you must pay the amount charged by the provider above the health plan reimbursement. This is because non-participating providers do not have a contract with the health plan to

	accept the negotiated reimbursement amount. These matters are set forth in your summary plan description and you should read that carefully. You should also be aware that some preferred provider plans have a much lower reimbursement for non-participating providers than for participating providers. Cost sharing provisions can result in your being out of pocket a substantial sum of money. Before you undergo treatment, find out from your healthcare provider what your out of pocket payment will be. Most health plans place a maximum limit on your total annual cost-sharing. If you read your health plan to find out what this limit is, you will know how much of a reserve to maintain for these costs.
Coverage Limitations	Health insurance does not cover everything. For example there is an exclusion for investigational or experimental procedures. This means that the health plan may not pay for something your doctor recommends for you if the scientific evidence supporting its effectiveness is not fully developed. This is just an example, the number of limitations on coverage are too numerous to be described here. You must read your summary plan description carefully to determine exactly what is covered and what is not. Coverage limitations can result in your being out of pocket a substantial sum of money because you may have to pay the full cost of treatment yourself. People are often surprised at how expensive medical treatment is. In an ideal world, we would all maintain a sizable cash reserve for these unexpected contingencies. Before undergoing treatment, consult with your healthcare provider to make sure that coverage will be available.
Deductible	The amount that must be paid by the insured before the insurer will begin paying for all or part of the remaining cost of covered services. Not applicable to HMOs.
Eligible Charge	The reimbursement to provider that is negotiated to be paid by a PPO. Typically less than the actual charge. Not applicable to HMOs.
Excluded Services	Health care services that your health insurance or plan doesn't pay for or cover.
Exclusive Provider Arrangement	A health plan that only covers services rendered by providers within its network.
Experience Rating or Merit Rating	A method of adjusting plan premiums based on the historical utilization data of a group of subscribers.
Fee For Service	Method of billing for health services under which a physician charges separately for each service rendered. Not applicable to HMOs.
Grievance	A complaint that you communicate to your health insurer or plan.
Health Insurance	A contract that requires your health insurer to pay some or all your health care costs in exchange for a premium.

HMO	Health maintenance organization. An organization that both finances and delivers health care. Physicians within the organization are not paid on a fee for services basis. Members of the HMO can usually receive services within the HMO by paying a small co-payment. Members of the HMO usually must use a primary care physician. (See also PPO vs. HMO.)
HSA	Health Savings Account. Tax free savings accounts used to pay medical expenses for individuals, spouses, or dependents. Savings rollover every year and funds are portable. HSAs are open to everyone with a high deductible plan. Contributions by individuals are tax deductible and contributions by employers are not included in taxable income. Contributions per year can be up to the amount of the policy's annual deductible. Funds can be used to pay deductibles, co-payments, prescriptions, over-the-counter drugs, long term care insurance, and premiums if individual is currently unemployed.
In-network Co-insurance	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 co-insurance usually costs you less than out-of-network co-insurance.
In-network Co-payment	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.
MSA	Medical Savings Account. Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers or employees are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and a Medical Savings Account (MSA) is the ability under an MSA to carry over the unused funds for use in a future year, instead of losing unused funds at the end of the year. Most MSAs allow unused balances and earnings to accumulate. Unlike FSAs, most MSAs are combined with a high deductible or catastrophic health insurance plan. It is a more restrictive version of a Health Savings Account (HSA). MSAs are limited to small business or self-employed individuals.
Mutual Benefit Society	A non-profit entity organized for the primary benefit of its members and beneficiaries. In Hawaii mutual benefit societies are primarily organized to provide sickness, disability, or death benefits to its members and their dependents.
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 pay more to see a non-

(or Non-Participating Provider)	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.
Open Enrollment Period	The yearly period when people can enroll in a health insurance plan. Outside the Open Enrollment Period, you generally can enroll in a health insurance plan only if you qualify for a Special Enrollment Period. (See Special Enrollment Period.) Jobs-based plans may have different Open Enrollment Periods. Check with your employer. You can apply and enroll in Medicaid or the Children's Health Insurance Program (CHIP) any time of year.
Out-of-network Co-insurance	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 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 health care 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-Pocket Limit	The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. 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 co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.
POS	Point of Service. A health plan that offers an HMO product combined with a PPO product.
PPO	Preferred provider organization. A network of healthcare providers that provides services at discounted rates in return for being part of the network. Using providers within the network is usually cheaper than using outside providers. Providers are reimbursed a percentage of the eligible charge, not the actual charge. Using an outside network provider may result in the member paying the actual charge of the service.
PPO vs. HMO	You should be aware of the difference between a preferred provider plan and a health maintenance organization. A preferred provider plan has a network of health care providers who contract with the health plan and are called participating providers. If you go to a provider outside the network, your out of pocket costs will be substantially higher. A health maintenance organization has a closed network of providers. You can only go outside the network if the health plan authorizes you to do so because the required services are not available within the network or if you are on the mainland and need emergency or urgent care. Choosing between a preferred

	provider plan and a health maintenance organization is a matter of personal choice and there are pros and cons to each. Differences can be researched with the health plans or on the Internet. Note that there may be hybrid products available such as a point of service plan that incorporates elements of an HMO and PPO.
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.
Preferred Provider (or Participating Provider)	A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers 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 not be as great, and you may have to pay more.
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.
Primary Care Provider	A generalist physician who is the primary contact and provides basic or general health care. The primary care physician determines whether the patient needs to see a specialist, go to a hospital, or requires other non-routine services. The goal is to guide the patient to appropriate services while avoiding unnecessary and costly referrals to specialists.
Prior authorization	A formal process requiring a provider to obtain approval to provide particular healthcare services or procedures before they are done.
Provider	A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.
Qualifying Life Event (QLE)	A change in your situation like getting married, having a baby, or losing health coverage that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside of the yearly Open Enrollment Period. (See Special Enrollment Period.) Job-based plans through your employer may have different Qualifying Life Events.
Referral	The process of sending a patient from one practitioner to another for health care services. HMOs often require that a gatekeeper or primary care physician authorize a referral for coverage of specialty services.

Special Enrollment Period (SEP)	A time outside of the yearly Open Enrollment Period when you can sign up for health insurance. You qualify for a Special Enrollment Period if you've had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child.
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.
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.