# Glossary

## A

*Allowable expense(s)*

Also called "covered expense(s)." The amount of a charge that is "covered," or **eligible** to be paid by a health insurance plan for **medically necessary** health care.

*AIDS Drug Assistance Programs (ADAP)*

Federal programs that pay for AIDS and HIV medication. ADAPs are for people with AIDS and/or HIV who meet certain **low-income requirements**. The programs operate in all states.

*Asset*

Owned property, like land or a car, that contributes to a person's total worth. Assets can also be used to settle debt.

*Authorization*

A health insurance plan's process for approving payment for medical services covered by an individual's plan. Depending on the plan, authorization may be required before services are provided, like before seeing a certain doctor or having surgery.

## B

*Beneficiary*

Someone who is covered under a health insurance plan. A child and his/her parents are beneficiaries of their insurance plan.

*Benefit*

The term "benefit" may refer in general to a health insurance plan (a person's "benefit"), specifically define the medical services covered under a particular plan (surgery could be a "benefit") or refer to the payment received for services covered under the plan.

*Brand name prescription drug*

A medication protected by patent which cannot be dispensed without a prescription from a health care professional. In health insurance plans that include **prescription drug** coverage, there may be differences in the price someone has to pay for a brand name drug versus a **generic** drug. Brand name drugs normally cost more than generic drugs.

## C

*Case management*

A process of identifying people who have certain health care needs and coordinating the care they receive.

*Claim*

Information submitted to a health insurance plan to request payment for medical services that are covered under that plan.

*Chronic condition*

A long-lasting medical condition that often requires treatment over a long period of time.

*COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986)*

A law that allows people to continue getting health insurance temporarily after they lose a job or experience a change in family status (like divorce). The cost of this continued insurance is paid by the person the plan covers. COBRA insurance may not be available through an employer with less than 20 employees.

*Co-insurance*

The portion of the cost of covered medical services that must be paid by the patient under a health insurance plan.

*Covered expense/Covered services*

See Allowable expense.

*Co-payment*

A specified dollar amount or percentage that a person is required to pay toward the cost of medical services that are covered under their health insurance plan. Like **co-insurance**, co-payments are usually applied after the person has paid their plan **deductible**, if necessary. Co-payments are different depending on the type of service.

## D

*Deductible*

A fixed amount that a person must pay for covered medical services before their health insurance plan will pay for them.

*Dependent*

A child or spouse of a person with a health insurance plan. A dependent can get health insurance through their spouse or parent's plan. There are usually limits for enrolling a dependent in a health insurance plan. For example, once a child turns a certain age, he/she may not be able to get insurance through their parent's plan.

*Diagnosis*

A term that describes the process of determining a person's medical condition. For example, after medical testing a person may be "diagnosed" as having a certain illness.

*Direct access*

Also called "open access." A term used to describe certain health insurance plans that allow people to go directly to any **participating health care provider** in the plan's **network** without a **referral** from a **primary care physician**.

*Disease management*

A program that uses many health resources to help prevent symptoms, maintain a high quality of life and prevent future need for medical care. It is for people with a specific illness or disease that use many health resources. Individuals enrolled in a disease management program may receive educational information, supplies and access to medical professionals to help them manage their illness.

*Durable medical equipment*

A piece of medical equipment, such as a wheelchair, that can be used repeatedly, serves a medical purpose and is appropriate for use at home. Other examples include hospital beds and oxygen equipment.

## E

*Early Periodic Screening, Diagnosis and Treatment (EPSDT)*

EPSDT is the child health component of Medicaid. It is required in every state and improves the health of low-income children by covering medical services like **well-child exams**, dental check-ups and vision and hearing screenings.

*Elderly*

A term used to describe older adults, typically people who are 65 or older.

*Eligibility requirements*

Requirements that people must meet before they can receive health insurance from a program or plan. Eligibility requirements for health insurance plans for the uninsured are normally based on the income, age and health of the person looking for insurance.

*Eligible*

A term indicating that a person has met the qualifications of a health insurance program or plan and is able to be covered.

*Emergency*

A serious medical condition resulting from injury or illness that arises suddenly and requires immediate medical attention.

*Enrollee*

Sometimes also referred to as a "member." A **subscriber** or **dependent** covered under a health insurance plan.

*Exclusion*

Also called "uncovered services." Specific conditions or services that are not covered under a health insurance plan.

## F

*Family planning*

A term used to describe a set of medical services related to reproductive health. These services typically include routine reproductive health screenings (like Pap smears and STD testing), pregnancy testing and information about birth control options.

*Federal Poverty Level (FPL)*

A term used to describe what the federal government considers the minimum amount of income a person or family can make to live an acceptable quality of life. People living below the Federal Poverty Level are considered to be living in poverty. This term is often seen in the **eligibility requirements** for health insurance plans for the uninsured. When a person's income is a certain percent below the FPL, this means that they make that much less than the poverty line.

*Fee-for-service*

A system that pays physicians or other **providers** a fee for each service they perform.

*Formulary*

A list of **prescription drugs** that are covered by a health insurance plan. A formulary generally includes both **brand name** and **generic** prescription drugs. Most **health benefits plans** that cover prescription drugs use a formulary. Within each category of covered drugs, they may provide different levels of coverage based on the cost of the drug or how well it works.

## G

*Generic prescription drugs*

A drug that is chemically the same as the **brand name** drug. It is typically made only after a brand name drug has been on the market for a few years and its patent has expired. Generic drugs are sold under the common name for the drug, not the brand name. They are normally less expensive than the brand name drug.

*Group coverage*

Plans that an employer or employee organization help pay for that provide health insurance to employees as well as former employees and their families.

## H

*Health benefits plan*

A health insurance plan purchased by a person or provided through an employer or government agency that covers health care services. Some plans are limited to particular types of services such as hospitalization or dental care; others provide a wide range of **benefits**. These benefits depend on certain exclusions and limitations.

*Health Insurance Portability and Accountability Act (HIPAA)*

HIPAA is a federal law that improves health insurance by doing things like limiting disqualification because of **pre-existing conditions** and prohibiting discrimination in enrollment and **premiums**. It also protects the security and privacy of people's health information.

*Health maintenance organization (HMO)*

A type of health insurance plan that provides or arranges for health services required by its **members**. In a traditional HMO plan, most services must be received from a **network** of health care **providers**. Certain HMO plans may offer reduced **benefits** for care received outside of the network. In most HMO plans, members are required to select a **primary care physician** (PCP) from the network to provide routine care. The primary care physician can also make **referrals** for specialty and hospital services when needed.

*Hospital pre-certification or pre-registration*

Under some health insurance plans, advance **authorization**, called pre-certification or pre-registration is needed, before the plan will pay for certain medical services, like going to the hospital.

## I

*ID card*

A card given to a person or **dependent** on a health insurance plan. The card may have important information relating to insurance, such as the plan's effective date, **co-payments**, contact information, etc.

*Immediate family*

A term used to describe people who are closely related. A person's immediate family is typically his/her spouse, children, parents and siblings. Many health insurance plans only cover someone's immediate family as **dependents**.

*Immunization*

A shot that prevents a disease. Many babies are required to receive certain immunizations at an early age.

*Income requirements*

Many health insurance plans for the uninsured only cover people who make below a certain amount of money. Some plans require different payment amounts which depend on how much money a person makes. Also see "Low-income."

*Individual policy*

Health insurance for individuals and their families. Individual policies are for people who are either self-employed or who are not offered health insurance through an employer or other group plan. People pay for individual policies on their own.

*In-network*

Refers to care received from **providers** who participate in a health insurance plan's **network** of **participating** physicians, hospitals and health care professionals. Many health plans provide more coverage for doctors in their network. Some plans only provide coverage for **emergency** services that are received outside of the network.

*Inpatient care*

Health care service provided after a patient is admitted to a hospital.

## K

*Katie Beckett option*

See Tax Equity and Fiscal Responsibility Act (TEFRA).

## L

*Length of stay*

The number of days in a row a person is in the hospital.

*Level of benefits/Level of coverage*

Terms that refer to how much a health insurance plan will cover. A plan with a high level of **benefits** or coverage typically covers many medical expenses and services.

*Low-income/Low-income requirements*

Low-income is a term used to describe people who make less than a certain amount of money each year. Many health insurance programs for the uninsured are only available to people who meet low-income requirements, or make below a certain amount of money. The amount of money that someone has to make in order to meet low-income requirements normally depends on the number of people in one's family. Also see "Income requirements."

## M

*Managed care*

Any form of health insurance plan that monitors health care services to see how well they work and how much they cost. Typical managed care plans provide a higher **level of benefits** for a select **network** of contracted health care **providers** and may require **preauthorization** for certain services.

*Mandated benefits*

Benefits that health insurance plans are required to provide by state or federal law.

*Medicaid*

A federal program that provides health insurance to **low-income** people. It is typically for children, adults with **dependent** children, pregnant women, the disabled and the **elderly**. Although it is a federal program, states help pay for Medicaid. Therefore, the program is different in every state. People should check with their state's Medicaid program to see if they are **eligible** for coverage.

*Medicare*

A federal program that provides health insurance to people 65 years or older, and some disabled people. There are different types of Medicare, like Medicare Part A, Part B, Part C and Medicare Part D.

*Medicare Part A*

A Medicare program that helps cover **inpatient** hospital care, care in nursing homes, hospice care and some home health care for qualified Americans age 65 and older and certain younger individuals with disabilities. Most people are required to pay for Part A insurance through taxes while working and, therefore, do not pay a **deductible** or **monthly premium**.

*Medicare Part B*

A Medicare program that covers doctors' services, **outpatient** hospital care, medical equipment, physical and occupational therapy and some home health care for qualified Americans age 65 and older and certain younger individuals with disabilities. Most people pay an annual **deductible** and a **monthly premium** for this health plan.

*Medicare Part C*

Also called "Medicare Advantage Plan." A Medicare program that provides more choices among health insurance plans and extends **benefits** beyond the original Medicare plan. It includes private Medicare Advantage plans (such as **HMOs** and **PPOs**) that provide Part A and B benefits, and may include Medicare **prescription drug** benefits. Nearly everyone with Medicare Parts A and B is **eligible** for a Medicare Advantage plan.

*Medicare Part D*

Also called "Medicare Prescription Drug Coverage." A Medicare program that helps cover **prescription drug** costs for qualified people who are **eligible** for Medicare Part A and/or B.

*Medically necessary/medically necessary services*

Medical services or supplies that are needed for the treatment of an illness or injury. Health insurance plans typically pay only for services and supplies that are medically necessary.

*Medigap*

Medigap plans help pay for certain services for people 65 or older who are not covered by traditional **Medicare**. Medigap may also pay for **co-insurance** or other fees that seniors are required to contribute to their Medicare plan.

*Member*

See Enrollee.

## N

*Necessary services or medical necessity*

See Medically necessary/medically necessary services.

*Network*

Also called "provider network." A group of physicians, hospitals and other health care professionals who provide services, typically at a discounted rate, for people on certain health plans. With certain plans, a person must get care from a network **provider** to avoid paying extra.

*Non-participating provider*

Also called “non-preferred provider.” This term refers to physicians, hospitals and other health care professionals who do not provide services at a discounted rate for people on certain health insurance plans. Seeing a non-**participating provider** typically costs more than seeing a doctor in the plan’s **network**.

## O

*Open access*

See Direct access.

*Out-of-pocket expenses*

**Co-payments** and **deductibles** that a person has to contribute toward the cost of health services covered by his or her health insurance plan. In some cases this term also includes amounts a person pays for health services not covered by their plan.

*Outpatient care*

A term used to describe care or surgery provided without an overnight stay in a hospital or other medical facility.

*Over-the-counter (OTC) drug*

Medication that may be purchased without a prescription (such as many cough syrups, cold medicines, pain relievers, etc.).

## P

*Participating provider*

Also called “preferred care provider.” A group of physicians, hospitals and other health care **providers** that provide services, typically at a discounted rate, for people on certain health insurance plans.

*Point-of-service (POS)*

A health insurance plan that provides insurance for care received from both **participating providers** and **non-participating providers**. In many POS plans, patients whose care is directed through **referrals** from their **primary care physician** (PCP) receive a higher **level of benefits** and pay less, while patients who go directly to other physicians or facilities receive a lower level of benefits and pay more.

*Poverty level*

See Federal Poverty Level (FPL).

*Preauthorization/Precertification*

See Authorization.

*Pre-existing condition*

A health condition (other than a pregnancy) or medical problem that was diagnosed or treated before getting insurance from a new health plan.

*Preferred provider organization (PPO)*

A health insurance plan that allows people to choose any **provider** without designating a **primary care physician** (PCP). PPOs offer higher levels of coverage to people who choose **participating** or preferred physicians or hospitals.

*Premium*

The amount charged for a health insurance policy. A person is often charged monthly or quarterly. If a person has health insurance through his/her employer, the cost of the premium is often shared with their employer.

*Prenatal*

A term used to describe care given to a mother before the birth of a child.

*Prescription drug/Prescription*

A medication that cannot be given without permission from a medical professional.

*Preventive care*

Care that helps people stay healthy (such as annual physical exams or **immunizations**) or is meant to detect early signs of disease (such as mammograms and colon cancer screenings).

*Primary care physician/Primary care provider (PCP)*

A physician who is part of a health insurance plan's **network** and serves as a patient's main point of contact for medical care. A PCP typically provides basic medical services and organizes other care. A PCP is usually a general or family care practitioner, or in some cases, an internist, pediatrician or OB/GYN. PCPs can provide patients with **referrals** for specialist care or other medical services.

*Provider*

A licensed health care facility, program, agency, physician or other health professional that provides health care services.

*Provider network*

See Network.

## Q

*Qualified immigrant*

A person who was not born in the United States but is in the country legally. A qualified immigrant must meet certain requirements to be allowed to receive health insurance through various plans or programs.

## R

*Reasonable charge*

Also called "usual, customary and reasonable (UCR)" or "customary and reasonable." A limit set by a health insurance plan on the amount that it will pay a **provider** for a specific medical service.

*Referral*

A referral is a specific set of directions or instructions from a **primary care physician** (PCP) which direct a person to a **specialist** or facility for **medically necessary** care. In some health plans, patients must receive a referral from their PCP before getting service from another doctor.

*Reimbursement*

Payment from a health insurance plan to a person on the plan to pay for medical expenses. Reimbursement can also be paid directly to a health care professional for services given to a person on the plan.

*Retroactive eligibility*

A term used to describe eligibility for a health insurance plan that covers services received prior to applying for the insurance. A person may be retroactively **eligible** even if they are not eligible at the time they apply.

## S

*Specialist*

A physician who provides care in a medical or surgical specialty (for example, dermatologists who provide skin care or oncologists who provide cancer care).

*State Children's Health Insurance Program (SCHIP)*

A federal program that provides health insurance to children in low-income families that make too much money to qualify for Medicaid, but still can't afford to buy their own insurance. SCHIP programs can also provide dental services for children up to age 19. Although it is a federal program, states help pay for SCHIP insurance, so it is different in every state. People should check with their state's program to see if their children are **eligible**.

*Subscriber*

A person covered under an employer's group health insurance plan. If an employer makes family insurance available, the subscriber may enroll their **eligible dependents** in the **benefits** plan.

*Supplemental Security Income (SSI)*

Income that certain people, like the disabled or blind, receive from the federal government.

## T

*Tax Equity and Fiscal Responsibility Act (TEFRA)*

Also called the "Katie Beckett option." TEFRA allows states to extend Medicaid coverage to certain disabled children. It provides care to disabled children in their homes rather than in institutions. It operates in most states and is for children who meet the Supplemental Security Income's (SSI) definition of disability. The children must also meet the medical-necessity requirement for institutional care.

## U

*Uncovered services*

See Exclusion.

*Urgent care*

Services received for an unexpected illness or injury that is not life threatening but requires immediate **outpatient** medical care. An urgent situation requires quick medical care to avoid complications and unnecessary suffering or pain.

## V

*Veterans Health Administration (VHA)*

The VHA provides health services, including preventive and primary care, and health insurance to enrolled veterans. A priority system ensures that veterans with service-connected disabilities and certain low-income veterans are able to be enrolled in the VA's health care system.

## W

*Well-baby/Well-child care*

Routine care for healthy children, including check-ups, tests and **immunizations**.