Section 3 – Health Insurance Concepts
Glossary

Appeal - An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies one of these:

- Your request for a health care service, supply, item, or prescription drug that you think you should be able to get
- Your request for payment for a health care service, supply, item, or prescription drug you already got
- Your request to change the amount you must pay for a health care service, supply, item or prescription drug.
- You can also appeal if Medicare or your plan stops providing or paying for all or part of a service, supply, item, or prescription drug you think you still need.

Beneficiary - A person who has health care insurance through the Medicare or Medicaid programs.

Benefit period - The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Benefits - The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents.

Children's Health Insurance Program (CHIP) - Insurance program jointly funded by state and federal government that provides health coverage to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but can't afford to purchase private health insurance coverage.

Claim - A request for payment that you submit to Medicare or other health insurance when you get items and services that you think are covered.

Coinsurance - A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges. The individual could also be responsible for any charges in excess of what the insurer determines to be "usual, customary and reasonable". Coinsurance rates may differ if services are received from an approved provider (i.e., a provider with whom the insurer has a contract or an agreement

specifying payment levels and other contract requirements) or if received by providers not on the approved list. In addition to overall coinsurance rates, rates may also differ for different types of services.

Coordination of benefits - A way to figure out who pays first when 2 or more health insurance plans are responsible for paying the same medical claim.

Copayment - An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cost sharing - An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. This amount can include copayments, coinsurance, and/or deductibles.

Coverage determination (Part D) - The first decision made by your Medicare drug plan (not the pharmacy) about your drug benefits, including:

- Whether a particular drug is covered
- Whether you have met all the requirements for getting a requested drug
- How much you're required to pay for a drug
- Whether to make an exception to a plan rule when you request it
- The drug plan must give you a prompt decision (72 hours for standard requests, 24 hours for expedited requests). If you disagree with the plan's coverage determination, the next step is an appeal.

Coverage gap (Medicare prescription drug coverage) - A period of time in which you pay higher cost sharing for prescription drugs until you spend enough to qualify for catastrophic coverage. The coverage gap (also called the "donut hole") starts when you and your plan have paid a set dollar amount for prescription drugs during that year.

Deductible - The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Excess charge - If you have Original Medicare, and the amount a doctor or other health care provider is legally permitted to charge is higher than the Medicare-approved amount, the difference is called the excess charge.

Fee-for-Service (FFS) Plan — Health coverage in which doctors and other providers receive a fee for each service such as an office visit, test, procedure, or other health care service. The plan will either pay the medical provider directly or reimburse you for covered services after you have paid the bill and filed an insurance claim. When you need medical attention, you visit the doctor or hospital of your choice.

Flexible Benefits Plan (Cafeteria plan) (IRS 125 Plan) – A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage.

Flexible Spending Accounts (or arrangements) (FSA) - Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Group health insurance plan - In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Guaranteed issue rights (also called "Medigap protections") - Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a Medigap policy, or place conditions on a Medigap policy, like exclusions for pre-existing conditions, and can't charge you more for a Medigap policy because of a past or present health problem.

Guaranteed renewable - An insurance policy that can't be terminated by the insurance company unless you make untrue statements to the insurance company, commit fraud, or don't pay your premiums. All Medigap policies issued since 1992 are guaranteed renewable.

Health care provider - A person or organization that's licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.

Health coverage - Legal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

Health Insurance Marketplace - A service that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace, available at HealthCare.gov, for most states. Some states run their own Marketplaces.
The Health Insurance Marketplace (also known as the "Marketplace" or "exchange") provides health plan shopping and enrollment services through websites, call centers, and in-person help.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - The "Standard for Privacy of Individually Identifiable Health Information (also called the "Privacy Rule")" of HIPPA assures your health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being.

Health maintenance organization (HMO) - A health care system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.

Health Savings Accounts (HSA) (Formerly a Medical Saving Account – Savings accounts designated for out-of-pocket medical expenses. In an HSA, employers and individuals 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 Health Savings Account (HSA) is the ability under an HSA to carry over the unused funds for use in a future year, instead of losing unused funds at the end of the year. Most HSAs allow unused balances and earnings to accumulate. Unlike FSAs, a HSA must include a high deductible or catastrophic health insurance plan.

Hospice - A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.

In-network - Doctors, hospitals, pharmacies, and other health care providers that have agreed to provide members of a certain insurance plan with services and supplies at a discounted price. In some insurance plans, your care is only covered if you get it from in-network doctors, hospitals, pharmacies, and other health care providers.

Lifetime reserve days - In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Long-term care - Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living, like dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living, or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don’t pay for long-term care.

Maximum out-of-pocket expense - The maximum dollar amount a group member is required to pay out of pocket during a year. Until this maximum is met, the plan and group member shares in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, often up to a lifetime maximum.

Medicaid - A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical emergency - When you believe you have an injury or illness that requires immediate medical attention to prevent a disability or death.

Medically necessary - Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medical underwriting - The process that an insurance company uses to decide, based on your medical history, whether to take your application for insurance, whether to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

Medicare - Medicare is the federal health insurance program for:

- People who are 65 or older
- Certain younger people with disabilities
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)

Medicare Advantage Plan (Part C) - A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans
- If you're enrolled in a Medicare Advantage Plan:
- Most Medicare services are covered through the plan
- Medicare services aren't paid for by Original Medicare
- Most Medicare Advantage Plans offer prescription drug coverage.
- Medicare Advantage Prescription Drug (MA-PD) Plan
- A Medicare Advantage plan that offers Medicare prescription drug coverage (Part D), Part A, and Part B benefits in one plan.

Medicare health plan - Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans. PACE plans can be offered by public or private companies and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare Medical Savings Account (MSA) Plan - MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare into the account. You can use the money in this account to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount so you generally will have to pay out-of-pocket before your coverage begins.

Medicare Part A (Hospital Insurance) - Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance) - Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare plan - Any way other than Original Medicare that you can get your Medicare health or prescription drug coverage. This term includes all Medicare health plans and Medicare Prescription Drug Plans.

Medicare Preferred Provider Organization (PPO) Plan - A type of Medicare Advantage Plan (Part C) available in some areas of the country in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare prescription drug coverage (Part D) - Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare. Part D adds prescription drug coverage to:

- Original Medicare
- Some Medicare Cost Plans
- Some Medicare Private-Fee-for-Service Plan

Medicare Medical Savings Account Plans - These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Medicare Private Fee-for-Service (PFFS) Plan - A type of Medicare Advantage Plan (Part C) in which you can generally go to any doctor or hospital you could go to if you had Original Medicare, if the doctor or hospital agrees to treat you. The plan determines how much it will pay doctors and hospitals, and how much you must pay when you get care. A Private Fee-for-Service Plan is very different than Original Medicare, and you must follow the plan rules carefully when you go for health care services. When you're in a Private Fee-for-Service Plan, you may pay more or less for Medicare-covered benefits than in Original Medicare.

Medigap policy - Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

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

Network pharmacies - Pharmacies that have agreed to provide members of certain Medicare plans with services and supplies at a discounted price. In some Medicare plans, your prescriptions are only covered if you get them filled at network pharmacies.

Original Medicare - Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Out-of-network - A benefit that may be provided by your Medicare Advantage plan. Generally, this benefit gives you the choice to get plan services from outside of the plan's network of health care providers. In some cases, your out-of-pocket costs may be higher for an out-of-network benefit.

Out-of-pocket costs - Health or prescription drug costs that you must pay on your own because they aren’t covered by Medicare or other insurance.

Penalty - An amount added to your monthly premium for Part B or a Medicare drug plan (Part D) if you don't join when you're first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

Pre-existing condition - A health problem you had before the date that new health coverage starts.

Premium - The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary care doctor - The doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Advantage Plans, you must see your primary care doctor before you see any other health care provider.

Primary care physician (PCP) - A physician who serves as a group member's primary contact within the health plan. In a managed care plan, the primary care physician provides basic medical services, coordinates and, if required by the plan, authorizes referrals to specialists and hospitals.

Referral - A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Reinsurance – The acceptance by one or more insurers, called reinsurers or assuming companies, of a portion of the risk underwritten by another insurer that has contracted with an employer for the entire coverage.

Respite care - Temporary care provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is the patient's caregiver can rest or take some time off.

Self-insured plan – A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage. Some self-insured employers contract with insurance carriers or third party administrators for claims processing and other administrative services; other self-insured plans are self-administered. Minimum Premium Plans (MPP) are included in the self-insured health plan category. All types of plans (Conventional Indemnity, PPO, EPO, HMO, POS, and PHOs) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees.

Stop-loss coverage – A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person’s health care (individual limit) or for the total expenses of the employer (group limit)

Supplemental Security Income (SSI) - A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 or older. SSI benefits aren't the same as Social Security retirement or disability benefits.