WELLFLEET
STUDENT

Glossary of Terms

Adjudication: The way a health plan decides how much it will pay for certain expenses.

Affordable Care Act (ACA): The comprehensive health care reform law enacted in March 2010.

Allowable Expense: The part of the bill that is eligible to be paid under your health plan.

Allowed Amount: A limit on the amount your health plan will pay. If you use an out-of-network provider your provider may not accept this payment in full and may bill you for the rest. This is in addition to your plan's copay and deductible.

Ancillary Services: These are services provided to support your health such as, lab tests and x-rays.

Appeals Process: This process lets you ask for a review of your claims denied by your health plan.

Balance Billing: Doctors and hospitals may bill a patient to make up the difference between their usual fee and the amount they are paid by the health plan. Doctors and hospitals participating in a PPO network will not do this.

Benefit: This refers to the medical services covered by your health plan. It can also mean payment received under a plan.

Board Certified: This describes health care practitioners who have met national standards for knowledge, skills and experience in a specialty area. These practitioners include doctors, physician assistants, dentists, pharmacists and nurses.

Brand-name drug: A drug sold by a drug company under a specific name or trademark. Brand-name drugs may be available by prescription or over the counter.

Broker: Insurance brokers are also called agents. They are licensed by states as agents, brokers or insurance producers. Insurance brokers help a person or business buy an insurance plan. The insurance plan can be bought through a health insurance exchange. Or it can be bought directly from an insurer. Brokers represent the person or business buying insurance. However, they are usually paid by a commission from the insurer.

Case Management: This is the way health plans help people with complex care needs. Case managers help coordinate care to help people improve their health.

Certificate of Coverage/Student Brochure: This details the benefits provided by your health plan. It lists what is covered and what is not covered. This document will be available after you sign up for a plan.

Claim: This is a request to be paid by a health plan for health services given. An example would be the claim your doctor sends to your health plan for an office visit.

Closed Formulary: A formulary is a list of prescription drugs the health plan covers. If the plan has a closed formulary, it only covers drugs that are on that list. It will not cover any part of the cost of non- formulary drugs. However, in some instances, a plan may be willing to make an exception. To get one, you need to contact the plan and tell them why the drug is needed.

Coinsurance: This is the percentage of health care expenses you pay after your deductible. Your health plan pays the rest up to any benefit or lifetime maximum.

Coordination of Benefits (COB): These rules are used to decide which plan pays first for people who have more than one plan. This helps coordinate coverage and allows claim information to be shared by the plans. This way, the plans can avoid duplicate payments

Copay/Copayment: This is the dollar amount you pay for health care expenses. In most plans, you pay this after you meet your deductible limit. For example, you pay a set dollar amount to your doctor for an office visit. So, if your copay is $25, you pay that amount when you go to your doctor. In prescription drug plans, it is the amount you pay for covered drugs.

Credentialing: This is a process. It is used to be sure doctors and hospitals meet certain standards. It is also used for other health professionals and facilities

Customary and reasonable: A limit on the amount your health plan will pay. Also called usual, customary and reasonable (UCR), reasonable, or prevailing charge. The limit is based on data the insurance company receives. The data is based on what doctors charge for the health care service. We receive this data from Fair Health, an independent organization.

Date claim received: This is the date the insurance company receives the claim.
Deductible: The amount you pay for covered services before your health plan begins to pay.

Drug: This is a natural or man-made substance used to treat an illness.

Drug formulary: Also known as a formulary. This is a list of prescription drugs the health plan covers. It can include drugs that are brand name and generic. Drugs on this list may cost less than drugs not on the list. How much a plan covers may vary from drug to drug. An open formulary provides a greater choice of covered drugs. It is also called a preferred drug list.

Drug tiers: These are groups of different drugs. Usually, the plans group the drugs by price. Each group or tier requires a different copay. You might see the groups listed as generic, brand-name, or preferred brand-name drugs. Generic drugs often have lower copays. Brand-name drugs have higher copays.

Effective Date: This is the date your health plan becomes active. Your coverage starts on this day.

Eligibility: This includes terms that decide who can get coverage. The requirements vary. They could include health conditions, how long a person is employed, job status and more.

Emergency: This is a serious illness or injury. It comes on suddenly. It is something that needs immediate medical care. If a person does not get care quickly, death or serious health problems may occur.

Electronic health record (EHR): This is a digital version of a patient's medical history. The goal is that all professionals involved in a patient's care enter details into this record. That could be your primary doctor or specialist. Or pharmacies, hospitals and labs. The EHR might include details like medicine taken, lab results and vital signs. Patient information can now be easily seen and shared across all providers so there's a broader view of a patient's health.

Enrollee: Also known as a member. A member is someone who belongs to a health plan. Sometimes a member is known as an enrollee

Exclusions: These are conditions or services that the health plan does not cover.

Experimental services or procedures: These are often newer drugs, treatments or tests. They are not yet accepted by doctors or by insurance plans as standard treatment. They may not be proven as effective or safe for most people.

Explanation of Benefits (EOB): This is a statement a health plan sends to a health plan member. It shows charges, payments and any balances owed. It may be sent by mail or e-mail.

Federally qualified health center (FQHC): These are federally funded nonprofit health centers or clinics. They serve medically underserved areas and populations. They provide primary care services. The amount they charge is based on the person's ability to pay.

Generic drug: A generic drug is a copy of a brand-name drug that no longer has a patent. The cost is usually less than the brand-name drug.

Health Insurance Portability and Accountability Act (HIPAA): This is a federal law. It limits the rules a group health plan can place on benefits for pre-existing health problems. It gives people access to quality health care coverage when they switch jobs. This law does not let group health plans charge higher rates because of a person's prior health status. It can also limit rules on some individual health plans. The law also helps protect private health information. It sets national standards for handling private health records.

ID Card: This is the card members get when they join a health plan. It helps doctors and other health care providers know what coverage a patient has. It shows the member's assigned plan number and plan contact information. Members should show the card at every health care visit.

In network: This means we have a contract with that doctor or other health care provider. We negotiate reduced rates with them to help you save money. Your out-of-pocket costs are lower when you stay in network.

There are other benefits to using doctors in network. They will not bill you for the difference between their standard rates and the rate they've agreed to with us. All you have to pay is your coinsurance or copay, along with any deductible. And network doctors will handle any precertification your plan requires.

Inpatient: This is a person who must stay in the hospital for care for at least one night.

Insurance card: Also known as ID card. This is the card members get when they join a health plan. It helps doctors and other health care providers know what coverage a patient has. It shows the member's assigned plan number and plan contact information. The card should be shown at every health care visit.

Length of stay: This is the number of days a patient stays in the hospital for treatment. Days are counted in a row.

Lifetime maximum: This is the total dollar amount of benefits you can receive. It can also be the total number of services you can receive. These totals are limits for a lifetime, not just for a plan year. Plans subject to federal health care reform can only have lifetime dollar maximums on non-essential benefits.
Limitations: These are restrictions that health plans place on coverage. They say what your plan does not cover.

Mail-order drugs: Also known as maintenance medications. These are prescription drugs that people take on a regular basis. These drugs help treat chronic conditions. These drugs include ones for asthma, diabetes, high blood pressure and other health conditions. Buying them through a mail-order pharmacy can save money.

Mail-order pharmacy: People can get prescription drugs through the mail with this. It is a service that health plans often offer. Members can save time and money using it by getting a three-month supply all at once.

Medically necessary: Health plans usually pay only for care that is necessary. They decide this by using medical standards or research that states what care is most effective. Care can mean health services or supplies. This also is called medically necessary, medically necessary services or medical necessity.

Network: A network is a group of health care providers. It includes doctors, dentists and hospitals. The health care providers in the network sign a contract with a health plan to provide services. Usually, the network provides services at a special rate. With some health plans, people get more coverage when they get care in the network.

Nonparticipating provider: This is a health care provider who does not have a contract with a health plan or network. People might pay more when they visit this kind of doctor, hospital or other health care professional. This may also be referred to as out of network or nonpreferred.

Open formulary: Some prescription benefits plans cover all eligible prescription drugs. This means they have an open formulary. In these plans, people might have lower copays for drugs on the preferred drug list. They might have higher copays for drugs that are not on this list.

Out of network: If you choose a doctor or other health care provider who is out of network, your health plan may pay some of that doctor's bill. But it will pay less than if you get care from a doctor in our network. You will pay more money if you decide to use a doctor that is not in our network.

Check your plan documents for more details: Your health plan documents will tell you how we pay for out-of-network care. Or call Member Services at the phone number listed on your ID card.

Out-of-pocket costs: These are medical costs that a member must pay. Copays and deductibles are examples.

Outpatient care: This is care a person gets in a clinic, emergency room, hospital or surgery center. The person goes home after the procedure. There is no overnight stay.

Over-the-counter drugs: These are drugs that can be bought without a prescription. They are not covered under most prescription benefits plans.

Participating pharmacy: This is a pharmacy that has a contract with a health plan or network. It fills covered prescriptions for plan members. Members might pay less for their prescriptions at this type of pharmacy.

PCP: Also known as primary care physician. This is a doctor who is part of a health plan's network. This doctor is a patient's main contact for care. PCPs give referrals for other care. They coordinate care their patients get from specialists or other care facilities. In some health plans, a person must choose a PCP to coordinate care.

Policy: Also known as a contract. This is a legal agreement. It is between a customer (an individual or group) and an insurance plan. It lists all details of the plan's coverage.

PPO: Also known as preferred provider organization. This is a type of health benefits plan. Members can choose any doctor. They do not have to name a primary care physician. No referrals are needed.
Members who go to network providers usually get more coverage. They may pay less for services.

Preferred provider organization (PPO): This is a type of health benefits plan. Members can choose any doctor. They do not have to name a primary care physician. No referrals are needed. Members who go to network providers usually get more coverage. They may pay less for services.

Prescription drug: This is any benefits plan or insurance plan that helps pay for prescription drugs.

Preventive care: This type of care is often covered in a health plan. It includes programs or services that can help people prevent disease. It may include yearly exams, shots and tests for some diseases. The tests are sometimes called screenings.

Provider: This term is used often by health plans. It means a licensed person or place that delivers health care services. Some examples are doctors, dentists, hospitals and more.

Provider network: Also known as network. A network is a group of health care providers. It includes doctors, dentists and hospitals. The health care providers in the network sign a contract with a health plan to provide services. Usually, the network provides services at a special rate. With some health plans, people get more coverage when they get care in the network.

Rx: This is a common symbol. It means prescription or pharmacy.

Second opinion: This is an opinion you get from a second doctor. You get this after you receive an opinion from the first doctor you went to see. It gives you a chance to compare the two opinions. Then you can decide how you want to treat your problem.

Step therapy: This is a way that a health plan controls drug costs. It means a person must try certain drugs before the plan will pay for a particular brand-name drug. The first drugs are often generic and cost less.

Summary of Benefits and Coverage (SBC): This document tells you what a health plan covers and what your share of the costs will be. For example, it lists your deductible, copay and out-of-pocket limits. All plans must use the same format for the SBC, so you can easily compare plans. You can check this document when shopping for or enrolling in a plan. Or you can ask for a copy from your insurance company or group health plan at any time.

Urgent care centers: These centers can treat urgent, but non-life-threatening medical issues. A few examples are sprains, fractures and minor burns.

Urgent care clinics are a convenient option to the emergency room. They're staffed with nurses and doctors. You wait less. You don't need an appointment. Many are open seven days a week. And you usually pay less.

If you have a medical issue that threatens your life, always visit your local emergency room first.

Usual, customary and reasonable (UCR): A limit on the amount your health plan will pay. Also called customary and reasonable, reasonable or prevailing charge. The limit is based on data received. The data is based on what doctors charge for the health care service. We receive the data from Fair Health, an independent organization.

Check your plan documents for more details. Your health plan documents will tell you how we pay for out-of-network care. Or call Member Services at the phone number listed on your ID card.

Wellness programs: These programs help people stay healthy. They may include ways to prevent disease, stay fit and care for one's own health. They show people healthier ways to live.