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## GLOSSARY OF COMMONLY USED TERMS

- **Allowable Charge:**  
The amount a benefit plan determines to be a reasonable charge for a service.
- **Ambulatory Surgery:**  
Surgery performed on an outpatient basis where the patient goes home the same day of the surgery.
- **Benefits:**  
The payments or value of services available under the coverage of a plan for treatment of medical costs.
- **Benefit Package:**  
The list of covered services a benefit plan offers to a group or individual.
- **Case Management:**  
Comprehensive coordination or supervision of a member's healthcare when the chronically ill or otherwise impaired person may require long-term care.
- **COBRA:**  
Consolidated Omnibus Budget Reconciliation Act. A federal law passed in 1985 that permits many people who lose eligibility under a group health plan to continue using that coverage.
- **Coinsurance:**  
The percentage of costs a patient pays out-of-pocket for medical care.
- **Coinsurance Maximum:**  
The total amount of coinsurance a member pays each year before the benefit plan pays 100% of allowable charges for covered services.
- **Concurrent Review:**  
A method of reviewing patient care during hospital confinement to validate the necessity of current care and to explore alternatives for inpatient care.
- **Continuum of Care:**  
The range of medical, nursing and social services most appropriate for the level or type of care required. For example, a hospital may offer services ranging from a nursery to hospice.
- **Conversion Plan:**  
A member's group plan is discontinued and the member chooses to continue coverage under an individual plan.
- **Coordination of Benefits:**  
A provision that applies when an individual has coverage under more than one plan. It is designed to avoid duplicate payment and to determine the plan that pays before the other.
- **Co-Payment (Co-Pay):**  
A supplemental cost-sharing arrangement in which the member pays the provider a specified amount for a specific service and the benefit plan pays the balance.
- **Customary and Reasonable:**  
Refers to the dollar amount allowed for a particular service and is often set by the insurance company or third-party payer. Companies typically establish this amount based on the average cost of the procedure in your geographical area. Also called Reasonable and Customary.
- **Deductible:**  
The annual amount a member must pay before the plan begins to pay full benefits.
- **Deductible Carry-Over:**  
In some benefit plans, this arrangement applies to bills received during the last three months of the year toward the deductible for the next year.

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- **Dependents:**  
Spouse and/or children (usually 18 or under or full-time students) defined as eligible in an employee benefit plan.
  - **Drug Formulary:**  
List of designated prescription drugs eligible for coverage by a managed care plan.
  - **Durable Medical Equipment:**  
Equipment which meets the following criteria: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally, is not useful to a person in the absence of illness/injury; and (d) is appropriate for home use.
  - **Effective Date:**  
The date on which the Health Plan Agreement goes into effect.
  - **Eligible Person:**  
A person who meets the qualifications of a health plan contract.
  - **Emergency Care:**  
Services provided in connection with an unforeseen acute illness or injury requiring immediate medical attention.
  - **EAP:**  
Employee Assistance Program. A program of counseling and other forms of assistance for alcoholism, substance abuse or emotional and family problems.
  - **ERISA:**  
Employee Retirement Income and Security Act. An act which places regulations on employee benefit plans, including health insurance.
  - **Enrollee:**  
An eligible employee or an eligible dependent of an employee who has enrolled in the plan. Synonymous with member and participant.
  - **Exclusions:**  
Specific healthcare services, sicknesses or injuries that aren't covered by the benefit plan.
  - **EOB:**  
Explanation of Benefits. A statement sent to enrollees explaining services provided, amount to be billed and payments made.
  - **HCFA:**  
Health Care Financing Administration. The agency within the Department of Health and Human Services which administers federal health financing and related regulatory programs, principally the Medicare, Medicaid and Peer Review Organization.
  - **HSA:**  
Health Savings Account. HSAs were created by the Medicare bill in 2003 and are designed to help individuals save for future qualified medical and retiree health expenses on a tax-free basis.
  - **Hospice Care:**  
Provide care to the terminally ill and offer respite care to family members.
  - **Lifetime Maximum Benefit:**  
The total amount of money a benefit plan will pay providers for the treatment of a patient.
  - **Managed Care:**  
Systems and techniques used to help direct the utilization, cost and quality of healthcare services. Includes a review of medical necessity, incentives to use certain providers and case management. Managed care is a broad term and encompasses many types of organizations, but it's generally used to describe the activity of organizing doctors, hospitals and other providers into groups to enhance the quality and cost-effectiveness of healthcare.
  - **Member:**  
An eligible employee or an eligible dependent of an employee who has enrolled in the plan. Synonymous with enrollee and participant.

- **Open Enrollment:**  
The annual period during which members can choose among the plans being offered by their place of employment.
- **Out-of-Pocket Maximum:**  
The total amount paid each year by the member for the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services for the rest of that calendar year.
- **Participant:**  
An eligible employee or an eligible dependent of an employee who has enrolled in the plan. Synonymous with enrollee and member.
- **PPO:**  
Preferred Provider Organization. An affiliation of healthcare providers, such as hospitals and physicians, who have agreed through formal agreements to provide healthcare at a discounted fee.
- **Pre-Authorization:**  
A process in which a member, doctor or hospital calls the benefit plan administrator for permission to carry out a medical treatment or procedure that will be covered under the benefit plan.
- **Preventive Care:**  
Proactive healthcare designed to keep members from getting sick or hurt. It often includes immunizations and screenings. A key part of preventive medicine is making sure patients know how to improve their health by altering their lifestyles.
- **Provider:**  
A doctor, hospital, laboratory or other person or company that takes care of healthcare needs.
- **Self-Funded:**  
A health plan for which the employer sets aside funds to cover employee medical claims and assumes the risk, as opposed to paying premiums to an insurance company. A third party usually handles claims administration.
- **TPA:**  
Third Party Administrator. An organization that administers healthcare benefits, mostly for self-funded employers.
- **Tertiary Care:**  
Specialized healthcare requiring sophisticated technology, multiple specialists and support facilities. Cancer care, brain surgery and burn care are examples of tertiary care services.
- **Utilization Review:**  
A process in which an insurance company reviews healthcare services provided by a doctor or hospital. The company conducts this review to ensure it is paying for appropriate healthcare services that produce desired outcomes.