Health Care Made Easy

Understanding health care can be difficult, but we've got you covered. Learn how to navigate commonly used terms with this Health Care Made Easy reference guide.

Aggregate Deductible vs. Embedded Deductible

An **aggregate deductible** is when the entire family deductible for a family health care plan must be met to receive a reimbursement from your insurance company. The deductible can be reached by one family member or a combination of members within the family. An **embedded deductible** is when individual members in a family health care plan only need to meet their own deductible before the insurance company will reimburse service charges.

Allowed Amount

This is the most money that your insurance company will pay toward a health care service. If your bill for a health care service exceeds the allowed amount, you might have to pay the difference. This may also be called "eligible expense," "payment allowance," or "negotiated rate."

Amount Billed/Billed Amount

This is the amount your doctor bills your health plan after providing you with health care services. This is not necessarily the amount your insurance plan will pay for these services, as health plans often negotiate payments with doctors to keep health care costs affordable.

Appeal

An appeal is your opportunity to dispute your insurance company's decision to not cover a certain health care service. In this situation, you can submit an appeal directly to your insurance company.

Balance Billing

When your health care service bill exceeds the allowed amount stated by your insurance company, you then have to pay the difference between the allowed amount and the total charge from your doctor.

EXAMPLE: If your doctor charges $100 for a service and the amount paid by your insurance company (the allowed amount) is $80, the doctor may send you a bill for the remaining $20.

In addition, there is an Out-of-Network state law mandated to create greater transparency within the health care system. The law protects patients from balance billing for "surprise bills" or emergency services bills from non-participating physicians. The law requires health plans to send notices to both members and providers when a claim – received for services from a NYS non-participating provider – was paid at usual and customary rates.

Benefit Year/Benefit Period
This is the year or period of time that your insurance coverage starts and stops. A benefit year can start and end at the beginning and end of a calendar year, but it can also vary depending on your plan.

Care Coordination
Care coordination involves the sharing of information among different health care providers (primary care physicians, your health insurance company, etc.) to ensure that you receive the appropriate health care services.

Carve-Out
An employer group utilizes a different insurance company to administer a specific benefit instead of its primary health insurance provider.

Coinsurance
The percentage of the bill you pay for a covered product or service. Unlike a copay, which is a flat amount, coinsurance is a percentage of the cost of the service. If your health plan has a deductible, the coinsurance is the amount you're responsible for after your deductible is met. If you receive services from an out-of-network doctor, you may be responsible for additional charges above the coinsurance.

EXAMPLE: Let's say you visit your doctor after your deductible is met. Now your plan requires a 20 percent coinsurance. If the doctor is paid $100 for the visit, you will owe $20.

Commercial Health Plans
A commercial health care plan is insurance coverage that is not provided by the state or federal government, but instead through a private or public company. This type of health care coverage is most often offered through an employer, providing employees the opportunity to select from different health benefit options that best suit their financial and medical needs.

Confinement
If you're in a situation where you need ongoing health care support, a doctor may place you in confinement at a hospital, nursing facility, or other health care program location. Once in stable condition, a doctor would formally discharge you from confinement before you can leave.

Copayment/Copay
The amount you pay for a health care service, like a doctor visit or a trip to urgent care. The amount depends on your plan and the type of service you receive. Keep in mind that if your plan has a deductible, you may be responsible for meeting your deductible first. Then, your copay will kick in. In addition, prescription medications also require copays, and they will vary depending on the medication.

EXAMPLE: You have a $20 copay for visits with your primary care provider (PCP) and a $40 copay for urgent care visits. This means you will pay $20 every time you go to your PCP and $40 every time you go to urgent care.

Deductible
The amount of money you pay for covered health care services before your health insurance starts to pick up the tab. If your cost exceeds the deductible, your plan will cover the remainder, or a percentage of the remainder. If you're in the process of choosing a health insurance plan, it is useful to know that plans with higher deductibles tend to have lower premiums.

EXAMPLE: If your deductible is $2,000, your insurance won't pay for anything until you have paid $2,000 for covered health care services. If you require a medical service that costs $3,000, you will pay the $2,000 deductible, and the plan will cover the remainder or a portion of the remaining $1,000.

Disallowed Amount/Write-Off
This is simply the difference between what your physician billed your insurance company and what the insurance company has paid. These amounts are not billed to the patient; instead, they are written off by the health care provider.

Emergency Medical Condition
An illness, injury, or symptom that would enable you to receive immediate care from a medical professional.

Emergency Services
This is simply the treatment of an emergency medical condition. A medical professional would address the emergency immediately to prevent the condition from getting worse.

Enhanced Primary Care (EPC)
A CDPHP-exclusive program that increases the value and quality of patient care, all while offering a unique payment model that encourages primary care doctors to spend more time with their patients.

ER, Urgent Care, or PCP?
While you may be familiar with the terms emergency room (ER), urgent care, and primary care physician (PCP), do you know which to visit for a health issue – and when?

Deciding the best course of action can be critical for getting the most effective care for your medical needs. A PCP knows your medical history and can treat you with your unique health needs in mind, while an urgent care facility can be very convenient when your doctor's office is closed. Of course, the ER is the best option when emergency care is needed.

Making the right choice can also save you money. While you should always go to the ER for serious health emergencies, visiting your PCP is a more cost-effective option under normal circumstances.

Excluded Services
Any health care service that your health insurance company does not pay for or will not cover.

Explanation of Benefits (EOB)
At first glance, it may appear to look like a bill – it's not. An EOB is a statement that your health plan sends in the mail after you receive a health service. It tells you how much the doctor charged, how much your insurance company will allow, how much your insurance paid, and the amount you may owe.

Fee Schedule

A list of health care service costs developed by your health insurance company. This list includes the maximum amounts that your health insurance will pay you (the member) for specified services. A fee schedule can include everything from primary care physician visit costs, to the cost of using an ambulance, to medical equipment fees.

Formulary

A list of prescription drugs your insurance company will pay for, based on the efficacy, safety, cost-effectiveness, and overall value of the drug. A formulary is typically divided into three tiers, with varying copay amounts (Tier 1 has the lowest copay and Tier 3 has the highest).

EXAMPLE: If your doctor prescribes you a new medication, it's always good to ask the physician if the drug is covered by your health insurance. The doctor will be able to tell if the drug is covered by looking up your plan's prescription drug formulary.

Funding Accounts

FSAs, HRAs, and HSAs are all types of funding accounts, and they can help you save money when it comes to your out-of-pocket medical expenses.

FSA: A flexible spending account (FSA) allows employees to set aside pre-tax dollars for specific, qualified health and/or dependent care expenses. The money is deducted directly from the employee's paycheck and is not subject to payroll taxes.

HRA: A health reimbursement arrangement (HRA) allows employers to set up and fund accounts that will reimburse employees for certain qualified medical expenses. It is owned by your employer, so if you leave your job, the account (and money in it) does not go with you.

HSA: A health savings account (HSA) is owned by the individual (not by the employer) and can be used to pay for qualified medical expenses without federal tax penalty. Unlike an HRA, because it is not owned by your employer, if you leave your job, the account (and money in it) goes with you.

Global Billing

Global billing was developed to simplify charges for complex health care services. For a specific set of health care services, you would receive one total bill instead of multiple bills from different providers.

EXAMPLE: Let's say you have surgery at a hospital. Instead of receiving individual bills from your doctor, the hospital, and technicians, along with equipment charges, you would be sent one comprehensive bill.

Grievance

If you have a complaint against your health insurance company, you can file a grievance. This complaint can be used to express dissatisfaction with any aspect of your health care plan.

Habilitation Services

Health care services that you would receive to learn or improve skills and functioning. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities. Habilitation services are held in a variety of inpatient and/or outpatient settings.

EXAMPLE: Therapy for a child who isn't walking or talking at the expected age.

Health Insurance Portability and Accountability Act (HIPAA)

A federal privacy law that sets national standards to protect individuals' medical records and other personal health information. The law gives patients more control over their health information, sets boundaries on the use and release of health records, and establishes safeguards that health care providers and others must meet to protect the privacy of health information.

EXAMPLE: If you call your health plan with questions about a claim for a dependent who's 18 or older, the health plan may not be able to provide you with these details, as the information is protected by federal privacy laws.

Hospice Services

Services that provide comfort and support in the last stages of a terminal illness. These services can be offered at a person's home, at a nursing home, or in a hospital.

Hospitalization

Admission into a hospital for health care services that usually requires an overnight stay.

In-network Coinsurance vs. Out-of-network Coinsurance

After your deductible is met, in-network coinsurance is the percentage of a health care service that you pay to a doctor who is contracted with your health insurance plan. Out-of-network coinsurance is the percent you pay for covered health care services to providers who do not contract with your health insurance company.

In-network coinsurance usually costs less than out-of-network coinsurance because there is a negotiated service price between the provider and your health insurance company.

In-network Copayment/Copay vs. Out-of-network Copayment/Copay

The amount you pay for a health care service to providers who contract with your health insurance company is an in-network copayment. An out-of-network copayment is the amount you pay for a health care service to a provider who does not have a contract with your health insurance company. In-network copayments usually cost less than out-of-network copayments.

EXAMPLE: You might pay a $20 copayment for a sick visit with an in-network doctor, where a sick visit with an out-of-network doctor might cost you a $50 copayment.

Long-Term Care

Assistance and care for a person with chronic disabilities. Long-term care supports chronic disabilities such as cancer, arthritis, asthma, eating disorders, and diabetes. These services are usually provided in a skilled nursing, intermediate care, personal care, or elder care facility.

Medicaid
Medicaid is a federal and state health care program offering free or low-cost medical coverage for those with low incomes and those with disabilities.

Medical Diagnosis
A medical diagnosis is simply the identification of an illness. Sometimes, medical diagnoses are made when you're not necessarily looking for them, like at your annual checkup. If this occurs, you may be charged a copay or coinsurance, as this falls outside your normal checkup.

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

Medicare
Medicare is a federally governed health care program for people ages 65 or older. Certain people with disabilities and those with end-stage renal disease are also eligible for this program. There are four basic components:

Medicare Part A (Hospital Insurance)
Covers inpatient services, including hospital stays, home health, hospice, and limited skilled nursing facility services.

Medicare Part B (Medical Insurance)
Covers outpatient services, including physician services, medical supplies, and other outpatient treatment.

After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Medicare Part C (Medicare Advantage Plans)
A managed Medicare Advantage plan. With this type of plan, qualified individuals and groups would have their Medicare coverage provided through an insurer, such as CDPHP. They must be eligible for Medicare Part A and Part B. Medicare Advantage plans can provide prescription drug coverage (Part D).

Medicare Part D (Prescription Drug Coverage)
A federal program to help cover the costs of prescription drugs for Medicare recipients in the United States.

Network
The facilities, providers, and medical suppliers your health insurance company has contracted with to provide health care services. A network could range from a primary care physician (PCP), to a chiropractor, to a nursing home.

Non-Routine/Sick Visit
Different from a routine or preventive visit, a non-routine or sick visit is used to detect or treat a medical diagnosis. The care received during a sick visit is also billed differently than a preventive exam and may result in out-of-pocket costs.

Out-of-Pocket Max

Many people don't realize that every health insurance plan sets a maximum for the amount you will have to pay, referred to as the out-of-pocket maximum (OOP max). Once you have reached your OOP max, your health insurance company will begin to pay 100 percent of your costs for covered care. Different plans have different OOP maximums.

EXAMPLE: Let's say your out-of-pocket maximum is $5,000. Once you pay $5,000 for covered health care services (this can include deductibles, copays, and coinsurance), your health insurance will pay 100 percent of the costs for covered care.

Outpatient Care/Ambulatory Care

Care in a hospital that doesn't require an overnight stay. Examples of hospital outpatient services include lab tests, physical therapy, minor surgeries, and X-rays. Outpatient services typically cost less than inpatient services since they do not require a patient to stay at a health care facility for an ongoing amount of time.

Physician Services

Health care services that a licensed medical physician (M.D. - medical doctor or D.O. - doctor of osteopathic medicine) provides or coordinates. The ultimate goal of physician services is to improve or maintain patients' health.

Point of Service (POS) Contract

If you were to use a medical provider outside of your health plan's network, you can work with your insurance company to create a managed care, or point of service, contract. If you choose to do that, you would be subject to higher copayments, deductibles, or coinsurance.

Preferred Providers vs. Non-Preferred Providers

To control costs, your health plan may create what's called a network of **preferred providers**, which can include doctors, hospitals, pharmacies, and other health care providers, where you pay less out of pocket. These networks vary by plan type, so it's always good to check with your health plan before visiting a health care provider in a non-emergency situation.

As opposed to a preferred provider, a **non-preferred provider** doesn't have an official service contract with your health plan. As a result, you'll pay more when using a non-preferred provider. Check your insurance policy to see if you can go to all providers who have contracted with your health plan or if your health plan has a "tiered" network where you must pay extra to see select providers.

Premium = Bill

A premium is the amount you pay for health insurance. It is, essentially, your bill for your health insurance – which could be due monthly, quarterly, or yearly. It's a bill you may or may not see, depending on the type of health insurance you have.

EXAMPLE: If you have health insurance through your employer, money may be taken out of your paycheck each month for health insurance. This is your insurance premium.

Prescription Drug Coverage

This is the portion of your health plan that helps to pay for your prescription medications.

Prior Authorization
Sometimes your health insurance plan requires that certain medical services be approved prior to you receiving them. This is called pre- or prior authorization, prior approval, or precertification. It allows your health insurance company to ensure that the care you are receiving is medically appropriate and delivered at the appropriate location.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Rehabilitation Services
Health care services to help regain skills and functioning. If you've been sick, hurt, or disabled and lost skills or functions as a result, you might utilize rehabilitation services. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services.

Riders
Optional benefits or benefit package not included in your standard health plan coverage that can be purchased for an additional premium. This would be considered an amendment to your insurance policy.

EXAMPLE: You may purchase a dental rider to add dental coverage to your medical insurance policy.

Routine/Preventive Visit
Routine or preventive visits are usually scheduled appointments that include a checkup, screenings, and counseling. They do not include tests or services to monitor or manage a condition or disease once it has been diagnosed. Depending on your plan type, the care provided during these visits is often covered at no out-of-pocket costs.

Skilled Nursing Care
Health care services provided by registered nurses (RNs) and/or specialized therapists (physical, speech, or occupational therapists). Skilled nursing care can support short-term needs such as a broken bone or long-term needs like cancer or asthma.

Specialist
A specialist is a doctor who focuses on a specific area of health care. Some specialist examples include cardiologists (heart), dermatologists (skin), pulmonologists (lungs), and ophthalmologists (eyes).

Timely Filing
A timely filing is basically the deadline by which a doctor has to submit a claim to an insurance company.

UCR (Usual, Customary, and Reasonable) Fees
To control expenses, insurance companies develop UCR fees. These are the determined amounts paid by your insurance company for a medical service. The fees are based on what providers in a geographic area usually charge for the same or similar medical services. The UCR amount is sometimes used to determine the allowed amount.

This document is intended to be an overview of commonly used health care terms; it is not meant to supplement or amend a member's policy. Members should review their contract for the definitions specific to their own plan.

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