GLOSSARY OF INSURANCE TERMS

Allowed amount: Maximum amount on which payment is based for covered healthcare services. This may be called "eligible expense," "payment allowance," or "negotiated rate." If a provider charges more than the allowed amount, the patient may have to pay the difference.

Balance billing: The amount a patient could be responsible for (along with any copayments, deductibles, or coinsurance) if a patient uses an out-of-network provider and the fee for a particular service is more than the charge allowed for that service.

Benefits investigation (BI): A process completed by Access 360™ to determine the insurance benefit coverage for a patient.

Carve-out: A healthcare service not covered under a patient's health insurance plan but usually reimbursed under a different contract.

Coinsurance: A patient's share of the costs of a healthcare service. A patient must also pay any deductibles still owed.

Copay: The fixed amount a patient must pay for a healthcare service, which can vary depending on the type of service (for example, emergency department visit, specialist's office visit). This amount is typically paid at the time of service. A patient may also have a copay when filling a prescription.

Deductible: The amount a patient must pay for healthcare services before the insurance company begins to make payments on claims.

Explanation of benefits (EOB): A statement sent from the health insurance company to a member that lists services that were billed by a healthcare provider, details how those charges were processed, and explains the total amount the patient owes on the claim.

Home health insurance: Health insurance that covers healthcare services provided to patients in their homes.

Home healthcare agency: An agency that offers healthcare services given to a patient at home for an illness or injury.

In-network copayment: A fixed amount (for example, $15) a patient pays for covered healthcare services to providers who contract with a patient's health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Length of stay (LOS): The total number of days that a patient stays in a facility such as a hospital.

Medicaid: A federally and state-funded medical insurance program for qualified low-income individuals.

GLOSSARY (cont)

Medical insurance: Insurance coverage for healthcare visits and medical procedures. A patient's pharmacy benefits may be included in the medical benefits, or they may be covered under a separate insurance plan.

Medical necessity: Justification for medical services that are reasonable, necessary, and/or appropriate based on clinical standards of care.

Out-of-network coinsurance: The percentage (for example, 40%) of the allowed amount that a patient pays for covered healthcare services to providers who don't contract with their health insurance or plan. Out-of-network coinsurance usually costs a patient more than in-network coinsurance.

Out-of-pocket (OOP): Medical expenses that aren't covered by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services, as well as costs for services not covered by insurance.

Payer: Entities other than the patient that help pay for the cost of healthcare services. "Payer" is often used as another name for an insurance company.

Peer review: The process by which a physician or team of healthcare specialists review the services, course of medical treatment, or the conclusions of a scientific medical study conducted by another physician or group of medical experts. Peer review must be provided by a physician or team of medical experts with training and expertise equal to that of the physician or team conducting the treatment or research in question.

Pharmacy insurance: Insurance coverage for prescription medications. Pharmacy benefits may be included in a patient's medical benefits, or they may be covered under a separate insurance plan.

Primary care provider (PCP): A healthcare practitioner who provides healthcare services for common illnesses and medical problems.

Prior authorization: A requirement that a physician must first obtain approval from a patient's health insurance plan in order for the product to be covered by the plan.

Referral: A written order from a primary care doctor for a patient 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.

Specialty pharmacy provider (SPP): A pharmaceutical entity that coordinates delivery of prescribed medication.

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