



Health Plan and Health Care Reform: **COMMON TERMS**



Note that your health plan or legal documents may have different explanations for some words below.

Terms and Definitions:

You can click on a term and link directly to its definition.

Allowed amount	Individual mandate
Appeal	Medi-Cal
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Contracted provider	Medicare
Co-pay	Network
Cost-sharing	Open enrollment period
Coverage (health coverage)	Out-of-pocket limit
Covered California (Exchange)	PPO (preferred provider organization)
Deductible	Pre-authorization
Emergency care	Pre-existing conditions
Evidence of Coverage (EOC)	Preferred provider
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Generic drug	Prescription drug coverage
Grandfathered health plan	Preventive care
Grievance	Primary care doctor
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Allowed amount

The most that a health plan will pay for a service.

In some plans, you pay a part of the allowed amount, and your health plan pays the rest. If you go to a doctor who charges more than the allowed amount, you may get a bill for the extra. A doctor who is part of your HMO or PPO should not bill you for the extra. The allowed amount may also be called eligible expense, payment allowance, negotiated rate, or contracted rate.

Annie went to a doctor who was not part of her PPO's network. Her health plan's allowed amount for the service was \$200. The doctor charged \$300 so Annie had to pay \$100 plus her co-insurance.

Appeal

A kind of complaint, in which you ask for a review of a health plan decision.

If your health plan says "no" when you ask for a service, you can file an appeal with the plan. This is called an internal appeal. You can also file an appeal with independent reviewers outside your plan. This is called an external appeal. You have a right to ask for both kinds of appeals.



Tom's health plan did not pay his emergency care bill, so he filed an appeal. The plan said "no" to his appeal, so he filed an external appeal.

Benefits (covered benefits)

Health care services offered by your health plan.

Covered benefits are the health care services your health plan pays for. Excluded benefits are the services that your health plan does not pay for.

Jane heard from a co-worker that the health plan they got through their workplace did not cover cosmetic surgery. She asked her health plan for a list of covered benefits and excluded benefits.

Co-insurance

A share of the cost of a health care service.

Co-insurance is a percent (%) of the bill for a service. This means that you pay more when the bill is larger.

Miguel sees a heart specialist in his health plan. The specialist charges \$200 for an office visit. Tom's co-insurance is 20 percent (20%), so he pays \$40. If Miguel gets a procedure that costs \$3,000, he pays \$600.

Contracted provider

A health care provider who has a contract with your health plan.



This is a provider who has a contract with your health plan to provide services to you at a lower cost. A contracted provider may also be called a preferred provider or a network provider.

Lauren always sees the contracted providers in her HMO.

Co-pay (co-payment)

A fixed charge (flat fee) for a health care service.

You usually pay the co-pay when you get the service. You pay the same fee each time.

Lily has an HMO. She pays a \$15 co-pay for each office visit, a \$200 co-pay for each visit to the emergency room, and a \$20 co-pay for generic prescriptions.

Cost-sharing

The part of your health care that you pay.

Cost-sharing is a general term that includes deductibles, co-insurance, and co-pays. Usually, it does not include premiums, balance bills, or services that your health plan does not cover.

Bill's plan has a deductible and co-insurance. Ann's plan has only co-pays. They have different kinds of cost-sharing.

Coverage (health coverage)

A general term for health care services offered by your health plan.

Health insurance companies and health plans provide coverage. Government programs like Medi-Cal also provide coverage.

What kinds of health care coverage does your health plan offer? Some health plans cover eyeglasses and some do not.

Covered California (Exchange)

A center to help individuals and small businesses find health plans.

Starting in late 2013, the Exchange can help you compare plans. It can also help you find out if you qualify for low-cost or free health care programs, or for tax credits to help you pay for a health plan.

Brenda has many different health plans in her area. When the Exchange in California opens, she will be able to get help comparing plans.

Deductible

The amount you must pay each year for health care before your health plan starts to pay.

Deductibles can vary a lot, and some plans have no deductible. Most plans pay for preventive care, like vaccines, even before you pay your deductible. Some plans have separate deductibles for prescription drugs or hospital care. Ask your health plan which costs count towards your deductible.

Lin's yearly deductible is \$1,000. She needs to pay hospital, doctor, and other bills up to \$1,000 before her health plan will start to pay for services. But Lin can get preventive care without paying the deductible.

Emergency care

Health care that you need right away.

It is an emergency if you have reason to believe that waiting for care could be dangerous to your life or to a part of your body.



You might need emergency care if you have a sudden illness, severe pain, a bad injury, or are in labor to have a baby.

Evidence of Coverage (EOC)

A guide to the services your health plan covers and does not cover.

It also explains what you pay for services. It is your contract with the health plan. Your health plan may give you a handbook, contract, policy, or letter of entitlement, instead of an EOC.

Barb looked at her Evidence of Coverage to find out what mental health care services were covered.

Formulary

A list of the prescription drugs that a health plan usually pays for.

Formularies include many kinds of drugs to treat many different conditions.

Jin's doctor gave him a new prescription. Jin asked his pharmacy to make sure that the drug was on his health plan's formulary.

Generic drug

A drug that is no longer owned by one company.



Generic drugs usually cost less than brand-name drugs, because no company owns the patent on them or can set the price. Generic

drugs have to meet the same quality standards as brand-name drugs.

Elizabeth's medicine became generic, so she changed to the generic. She now pays \$15 for the generic drug instead of \$35 for the brand-name drug.

Grandfathered health plan

A health plan that started before March 23, 2010.

There are 2 kinds of grandfathered plans:

- 1) An individual plan that you joined before March 23, 2010.
- 2) Or a group plan that your employer started before March 23, 2010, even if you joined the plan later.

Grandfathered plans do not have to follow parts of the new health care reform law. To find out if your plan is a grandfathered health plan, contact your plan or employer. Over time, if a grandfathered plan makes important changes in its costs or benefits, it is no longer grandfathered and has to follow the new laws.

Jack's health plan does not follow all the new health care laws. This is because it started before March 23, 2010 and is a grandfathered health plan.

Grievance

A complaint that you make to your health plan.

In a grievance, you ask your health plan to solve a problem or change a decision they made about your care. You can file a grievance by mail, phone, and sometimes online.



Sam could not get an appointment with a specialist for 3 months. He filed a grievance online, asking his health plan to fix the problem.

Group coverage (group health plan)

This is coverage that you get through a job, union, or other group.

Some of the rules for group coverage are different from the rules for individual coverage, which you buy on your own.

Mary worked for a company with 230 employees and got group coverage health care through her work. Her sister was self-employed and bought individual coverage for her health care.

Health insurance

Insurance that helps pay for health care costs.

The insurance policy or contract states the fees you have to pay and the services your health insurance pays for.

Jan's health insurance covers preventive care, as well as care for illnesses and emergencies.

HMO (health maintenance organization)

A kind of health plan.

With an HMO you get all your health care from one group of doctors, hospitals, and labs. This group is also called a network. You have a main doctor, also called your primary care doctor, who oversees your care.

Allen has an HMO. He usually sees his primary care doctor first when he has a problem. Then his doctor gives him referrals to other doctors in his HMO for the other care he needs.

Independent medical review (IMR)

A review of a health plan decision by doctors outside the plan.

An IMR is an external appeal. Doctors or other health care professionals review your case. They decide whether your plan must pay for the treatment you want. Your health plan must do what



the IMR says. You may qualify for an IMR if your plan denies the care you need and says it is not necessary or is experimental. You may also qualify for IMR if

your plan does not pay for emergency or urgent care that you have already received.

Tony's health plan did not authorize a procedure he needs. The plan said it was not medically necessary. Tony filed an appeal with his plan, but they said "no." He then asked the state for an IMR. The IMR decided that Tony's health plan should pay for the procedure.

Individual coverage (individual health plan)

This is a health plan you buy yourself.

Some of the rules for individual coverage are different from the rules for group coverage, which you usually get through a job.

Gilberto bought individual coverage because he worked for himself. His brother had group coverage from his workplace.

Individual mandate

This is a law that requires most people to have health coverage.

It starts in 2014. There will be health care programs for people with no income or low incomes. There will be a tax break for people with lower incomes who buy health insurance. There will be a tax penalty for people who do not buy health insurance.

Randy does not have health insurance. There will be programs to help him find coverage in 2014.

Medi-Cal

A state government health care program for people with low incomes.

Medi-Cal is the California name for the national Medicaid program. Medi-Cal is free for some people. Other people pay a share of their Medi-Cal costs. There are many ways to qualify for Medi-Cal, but you must have a low income.

Fran has a low income. She cannot work because she has a serious heart condition. She is applying for Medi-Cal so that she'll have health care coverage.

Medical group

A group of doctors who have a contract with a health plan.

Medical groups include primary care doctors, specialists, and other providers. In some health plans, you get most of your care from your primary care doctor's medical group. A medical group is sometimes called an Independent Practice Association (IPA).

Ella needed to see a dermatologist. She asked her primary care doctor for a referral to a dermatologist in her medical group.

Medically necessary care

Care that you need in order to prevent, find, or treat a health problem.

In general, health plans only cover medically necessary care. This care must meet accepted standards of medicine. There should be evidence that you need the treatment and that it can help problems like yours.

Andy wanted surgery on his sinuses. His plan said it was not medically necessary. It said that sinus problems like his usually improved on their own, without surgery, and there was not enough evidence that the surgery would help. Andy can file an appeal if he wants to.

Medicare

A government health insurance program for people who are 65 and older and some people with disabilities.

Most Americans age 65 and older have Medicare.



Yolanda just turned 65 years old and can now get Medicare health benefits.

Network

All the doctors, hospitals, labs, and other providers that have contracts with your health plan.

This network provides all or most of your health care services. Some plans have a network with different levels, called a tiered network. This means that you must pay extra to see some providers, even if they are in your network. Providers in your network may be called preferred or contracted providers.

Kim's HMO will not pay for the services she gets from doctors outside the network, except in a few special cases. So when Kim needed to see a cardiologist, she went to one in her network.

Open enrollment period

The time when you can change your health benefits.

This usually happens once a year at your job.

Marianne wants to change from an HMO to a PPO but she has to wait until her employer's open enrollment period.

Out-of-pocket-limit

This is the most you have to pay for most health care services in one year.

This limit may include your deductible. Ask your health plan which costs count towards your out-of-pocket limit.

Eric's out-of-pocket limit is \$7,000. Eric usually pays a co-insurance of 20 percent of each bill he gets. When he has paid a total of \$7,000, he can stop paying co-insurance.

**PPO
(preferred provider
organization)**

A kind of health plan.

With a PPO you can go to doctors inside or outside your network. But if you go to a doctor outside of your network, you will have to pay more.

Melissa had to choose between a PPO and an HMO. She chose the PPO because she wanted to see some doctors outside the PPO network.

Pre-authorization

A decision by your health plan that health care service is medically necessary.

You may need pre-authorization for certain services before you receive them. Pre-authorization is also called prior authorization, prior approval, pre-approval, or precertification.

Leon's doctor ordered an X-ray of his spine. The doctor said he should not get the X-ray until he had pre-authorization from his health plan.

**Pre-existing conditions**

Medical problems you have before you try to buy or join a new health plan.

Some health plans will not accept you if you have a pre-existing condition, or will limit or deny coverage for these conditions. This will no longer be allowed, starting in 2014.

Marty had several bad asthma attacks. It was hard for her to find a health plan that would accept her.

Preferred provider

A health care provider who is in your health plan's network.

This is a provider who has a contract with your health plan to provide services to you at a lower cost. A preferred provider may also be called a contracted or network provider.

Elisa usually goes to preferred providers in her PPO. If she goes to other providers, she pays more.

Premium

The amount you pay each month to keep your health plan.

Your employer or the government may pay all or part of your premium.

Bonnie paid part of the premium for her health plan each month. Her employer paid the rest.

**Prescription drug
coverage**

Coverage that helps pay for prescription drugs.

In 2014, most new health plans will cover prescription drugs.

Carl's current health plan does not cover prescription drugs. He wants to look for a new plan, with drug coverage, in 2014.

Preventive care

Health care that helps keep you healthy.

This includes tests or exams that can help doctors find health problems early when they are easier to treat. In most health plans, you can get preventive care services, like vaccines, without paying a deductible, co-pay, or co-insurance.

Nancy asked her doctor which preventive care services she should get, when she should get them, and if they were free.

Primary care doctor

Your main doctor, who gives you most of your care and refers you for other services and providers when you need them.

In many health plans you must have a primary care doctor. Your primary care doctor will refer you for other services when you need them. Instead of a doctor, you may see a nurse practitioner, clinical nurse specialist, or physician assistant. This person is called your primary care provider.

Molly's primary care doctor knows her and helps keep track of her health care needs.

**Provider**

A trained medical professional or a health care facility such as a hospital.

Providers are licensed, certified, or accredited by state law.

Doctors, labs, clinics, hospitals, and pharmacies are health care providers.

Referral

A request from your doctor, asking another provider to see you.

You often need a referral before you can get care from other providers, such as specialists and labs. Your doctor usually faxes or emails the referral to the other provider. You can ask for a copy of the referral. It explains why you need to see the other provider. Sometimes your plan has to pre-authorize the referral.

Joe's primary care doctor gave him a referral to a skin doctor because he had a rash on his hands that would not go away.

Self-insured plan

A kind of health plan used by many large employers.

In self-insured plans, the employer sets aside a pool of money, including employee premiums, and uses it to pay for the health care of employees. Some health plan laws do not apply to these plans. However, you do have a right to file a grievance and appeal if you have a problem with a self-insured plan. Self-insured plans are also called self-funded plans.

Jeff worked for a large school district that had a self-insured plan.

Summary of benefits

A short list of the costs and benefits in a health plan.



You can compare plans, or learn about your own plan, by looking at the summary of benefits.

Maya's job offered 3 different health plans. She compared the Summary of Benefits for each plan. She chose the one with the best costs and benefits for her family.