CCHI Mini-Glossary Project Glossary #4
Subject: Affordable Care Act - Insurance
Language: English

Note: Some terms and definitions are from the *Benefits and Coverage Uniform Glossary* by Centers of Medicaid and Medicare Services (See: http://www.cms.gov/cciio/Resources/forms-reports-and-other-resources/index.html#Summary%20of%20Benefits%20and%20Coverage%20and%20Uniform%20Glossary).

#	English	Your Translation into:	Definition
1.	**Affordable Care Act (ACA)** *Syn.* **Health Care Reform; Obamacare**		The comprehensive federal health care reform law enacted in March 2010.
2.	**Health Insurance**		A contract that requires an individual's health insurer to pay some or all of their health care costs in exchange for a premium.
3.	**Health Insurance Marketplace** *Syn.* **Exchange**		State- or federally run and regulated market where an individual can shop, compare, and buy health care coverage.
4.	**Eligibility requirements**		Conditions that must be met in order for an individual or group to be considered eligible for insurance coverage.
5.	**Open enrollment (period)**		A period of time each year when an individual can purchase or change health coverage.
6.	**Medicaid**		Health insurance provided by the government to some low-income people, families and children, pregnant women, the elderly, and people with disabilities. In some states the program covers all adults below a certain income level. Medicaid programs must follow federal guidelines, but coverage and costs may be different from state to state.
7.	**Children's Health Insurance Program (CHIP)**		Health insurance provided by the government to children in families that earn too much money to qualify for Medicaid. In some states, CHIP covers parents and pregnant women. Each state works closely with its state Medicaid program. In many cases, if an individual qualifies for Medicaid your children will qualify for either Medicaid or CHIP.
8.	**Medicare**		A federal health insurance program, administered by the Social Security Administration, that provides health care for most people over 65 and certain other eligible individuals.
9.	**Health plan**		A benefit an individual's employer, union or other group sponsor provides to that individual to pay for their health care services.
10.	**Secondary coverage**		When a person is covered under more than one health insurance plan, this term describes the health insurance plan that provides payment on claims after the primary coverage (i.e. main plan).

11.	**Managed care**		A general term used to describe a variety of health care and health insurance systems that attempt to guide a patient's use of benefits, typically by requiring that a patient coordinate his or her health care through a primary care physician, or by encouraging the use of a specific network of healthcare providers. The management of health care is intended to keep costs -and monthly premiums- as low as possible. Examples of managed care plans include: • Health maintenance organizations (HMOs), • Preferred provider organizations (PPOs), • Exclusive provider organizations (EPOs), and • Point of service plans (POSs).
12.	**Premium**		The amount that must be paid for an individual's health insurance or plan. The individual and/or their employer usually pay it monthly, quarterly or yearly.
13.	**Dependent**		A spouse, child, or domestic partner who is covered under a policyholder or subscriber's plan, depending on applicable law and the plan's terms and conditions.
14.	**Covered services**		Health care services that are included in and paid for by an individual's health insurance or plan.
15.	**Excluded services**		Health care services that an individual's health insurance or plan doesn't pay for or cover.
16.	**Pre-existing condition**		A medical condition that a person has before being enrolled in a health plan.
17.	**Service area**		The geographic area in which a health insurance plan's benefits are made available. Some health insurance plans will not provide coverage outside of a plan's service area.
18.	**Network**		The facilities, providers and suppliers an individual's health insurer or plan has contracted with to provide health care services.
19.	**Provider**		A physician (M.D.– Medical Doctor or D.O.– Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.
20.	**Primary Care Provider/ Physician (PCP)**		A physician (M.D. – Medical Doctor or D.O.– Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.
21.	**Specialist**		A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

22.	**Preferred provider**		A provider who has a contract with an individual's health insurer or plan to provide services to them at a discount. Health insurance plans can have a "tiered" network, meaning the individual must pay extra to see some non-preferred providers.
23.	**Participating provider**		Generally, this term is used in a sense synonymous with Network Provider. However, not all healthcare providers contract with health insurance companies at the same level. Some providers contracting with insurers at lower levels may sometimes be referred to as "participating providers" as opposed to "preferred providers."
24.	**Non-preferred provider**		A provider who doesn't have a contract with an individual's health insurer or plan to provide them with services. The individual pays more to see a non-preferred provider.
25.	**Cost share**		The portion of charges for a service or prescription that an individual is responsible for paying, such as a copayment, coinsurance, or deductible payment.
26.	**Co-insurance**		An individual's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. The individual pays co-insurance plus any owed deductibles.
27.	**Co-payment**		A fixed amount (for example, $15) an individual pays for a covered health care service, usually when they receives the service. The amount can vary by the type of covered health care service.
28.	**Deductible**		The amount an individual owes for health care services their health insurance or plan covers before the individual's health insurance or plan begins to pay. For example, if an individual's deductible is $1000, their plan won't pay anything until they've met their $1000 deductible for covered health care services subject to the deductible.
29.	**Allowed amount** *Syn.* **Eligible expense; Payment allowance; Negotiated rate**		Maximum amount on which payment is based for covered health care services. If the individual's provider charges more than the allowed amount, the insured may have to pay the difference.
30.	**Usual, Customary, Reasonable (UCR) charge**		The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.
31.	**Balance billing**		When a provider bills an individual for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill the individual for the remaining $30.
32.	**Out-of-pocket costs**		Any amounts an individual pays for covered services, not including their monthly premiums.

33.	**Out-of-pocket limit** *Syn.* **Out-of-pocket maximum**		The most an individual pays during a policy period (usually a year) before their health insurance or plan begins to pay 100% of the allowed amount. This limit never includes the premium, balance-billed charges or health care the individual's health insurance or plan doesn't cover.
34.	**In-network payments**		Payments (co-insurance, co-payment) for covered health care services to providers who contract with an individual's health insurance or plan.
35.	**Out-of-network payments**		Payments (co-insurance, co-payment) for covered health care services to providers who ***do not*** contract with an individual's health insurance or plan. Out-of-network payments are usually high than in-network ones.
36.	**Medically necessary**		Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
37.	**Preauthorization** *Syn.* **Prior authorization; prior approval; precertification**		A decision by an individual's patient's health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. The health insurance or plan may require preauthorization for certain services before the individual receives them, except in an emergency. Preauthorization isn't a promise an individual's health insurance or plan will cover the cost.
38.	**Grievance**		A complaint that an individual communicates to their health insurer or plan.
39.	**Appeal**		A request by an individual to their health insurer or plan to review a decision or a grievance again.
40.	**Physician services**		Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.
41.	**Ambulatory care**		Medical care provided on an outpatient basis which may include diagnosis, certain forms of treatment, surgery and rehabilitation.
42.	**Hospitalization**		Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.
43.	**Hospital Outpatient Care**		Care in a hospital that usually doesn't require an overnight stay.
44.	**Prescription drug coverage**		Health insurance or plan that helps pay for drugs and medications that by law require prescription.

45.	**Emergency medical condition**		An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.
46.	**Emergency room care**		Emergency services an individual gets in an emergency room, i.e. Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
47.	**Emergency medical transportation**		Ambulance services for an emergency medical condition.
48.	**Urgent care**		Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.
49.	**Chronic disease management**		Health care provided to patients with chronic conditions such as diabetes, asthma, heart disease, depression, etc.
50.	**Long-term care**		Care provided on a continuing basis for the chronically ill or disabled. Long-term care may be provided on an inpatient basis (at a long-term care facility) or in the home setting.
51.	**Nursing home**		A licensed facility which provides general nursing care to those who are chronically ill or who require constant supervision and assistance with the needs of daily living.
52.	**Palliative care**		Specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.
53.	**Preventive care** *Syn.* **Preventive & wellness services**		Health services provided to prevent diseases (or injuries) rather than curing them or treating their symptoms. Examples include routine examinations and immunizations.
54.	**Annual physical examination** *Syn.* **Routine physical; Annual check-up**		A yearly medical examination by a physician or nurse practitioner to determine the state of a person's health, identify risk factors for disease, and devise strategies for disease prevention.
55.	**Maternity and newborn care**		Health care for pregnant women and newborns.
56.	**Mental health services** *Syn.* **Behavioral health services**		Care provided for people with mental illnesses and those who are at-risk.
57.	**Substance use disorder services**		Care provided to people with addictions and substance use problems.

58.	**Home health care**		Health care services a person receives at home.
59.	**Skilled nursing care**		Services from licensed nurses in an individual's own home or in a nursing home. Skilled care services are from technicians and therapists in their own home or in a nursing home.
60.	**Rehabilitation services**		Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.
61.	**Habilitation services**		Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
62.	**Physical therapy**		A form of rehabilitative care that uses specially designed exercises and equipment to help patients regain or improve their physical abilities such as walking, the use of limbs, etc.
63.	**Occupational therapy**		A form of therapy for those recuperating from physical or mental illness that encourages rehabilitation through the performance of activities required in daily life.
64.	**Speech-language pathology**		A form of therapy for the improvement or cure of communication disorders, including speech, language, and swallowing disorders.
65.	**Hospice services**		Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
66.	**Respite care**		Normally associated with hospice care, this service is often made available for family members of a patient, providing the patient's primary caretaker with a break or respite from caring for the patient. Respite care may be provided for the patient in either the home or a nursing home setting.
67.	**Durable Medical Equipment (DME)**		Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.
68.	**Ancillary services**		Supplemental healthcare services such as laboratory work, x-rays or physical therapy that are provided in conjunction with medical or hospital care.