



1199SEIU Benefit and Pension Funds

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#), [Summary Plan Description \(SPD\)](#) or [health insurance](#) policy. Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [co-insurance](#) and [out-of-pocket limits](#) work together in a real-life situation.

Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered healthcare service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the [provider's](#) charge is \$200 and the [allowed amount](#) is \$110, the [provider](#) may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider \(non-preferred provider\)](#). A [network provider \(preferred provider\)](#) may not bill you for covered services.

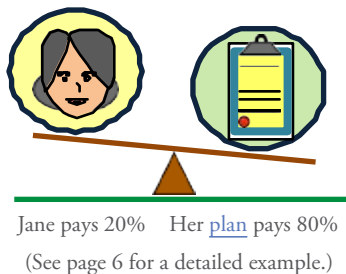
Claim

A request for a benefit (including reimbursement of a healthcare expense) made by you or your healthcare [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Co-insurance

Your share of the costs of a covered healthcare service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay [co-insurance](#) *plus* any [deductibles](#) you owe.

(For example, if the [health insurance](#) or [plan's allowed amount](#) for an office visit is \$100 and you've met your [deductible](#), your [co-insurance](#) payment of 20% would be \$20. The [health insurance](#) or [plan](#) pays the rest of the [allowed amount](#).)



Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Co-payment

A fixed amount (for example, \$15) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Cost Sharing

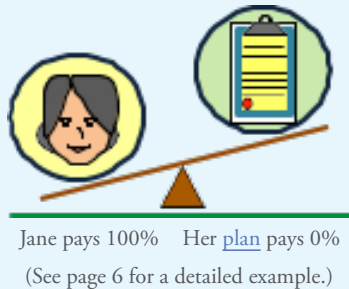
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called “[out-of-pocket](#) costs”). Some examples of cost sharing are [co-payments](#), [deductibles](#) and [co-insurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay or the cost of care a [plan](#) doesn't cover, usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver-level health [plan](#) or if you're a member of a federally recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered healthcare services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (For example, if your deductible is \$1,000, your [plan](#) won't pay anything until you've met your \$1,000 deductible for covered healthcare services subject to the deductible.)



Diagnostic Test

Tests to figure out what your health problem is. For example, an X-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a healthcare [provider](#) for everyday or extended use. DME may include oxygen equipment, wheelchairs and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain) or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention, you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

Excluded Services

Healthcare services that your [plan](#) doesn't pay for or cover.

Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost-sharing](#) levels or tiers. For example, a formulary may include generic drug and brand-name drug tiers, and different [cost-sharing](#) amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or [plan](#).

Habilitation Services

Healthcare 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.

Health Insurance

A contract that requires a health insurer to pay some or all of your healthcare costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)."

Home Health Care

Healthcare services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers or other licensed healthcare [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement

Sometimes called the “individual mandate,” the duty you may have to be enrolled in health coverage that provides [minimum essential coverage](#). If you don't have [minimum essential coverage](#), you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Co-insurance

Your share (for example, 20%) of the [allowed amount](#) for covered healthcare services. Your share is usually lower for [in-network](#) covered services.

In-network Co-payment

A fixed amount (for example, \$15) you pay for covered healthcare services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network co-payments usually are less than [out-of-network co-payments](#).

Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare [plans](#) based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange.” The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone and in-person.

Maximum Out-of-Pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, [in-network](#) services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

Medically Necessary

Healthcare services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, including [habilitation](#), and that meet accepted standards of medicine.

Minimum Essential Coverage

Health coverage that will meet the [individual responsibility requirement](#). Minimum essential coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#), or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you're offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost-sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide healthcare services.

Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms and eyes, and external breast prostheses after a mastectomy. These services include adjustment, repairs and replacements required because of breakage, wear, loss or a change in the patient's physical condition.

Out-of-Network Co-insurance

Your share (for example, 40%) of the [allowed amount](#) for covered healthcare services to [providers](#) who don't contract with your [health insurance](#) or [plan](#). Out-of-network co-insurance usually costs you more than [in-network co-insurance](#).

Out-of-Network Co-payment

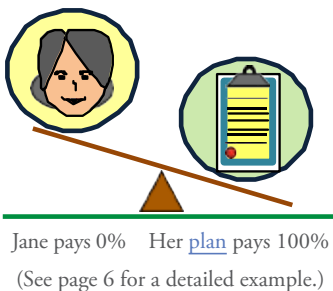
A fixed amount (for example, \$30) you pay for covered healthcare services from [providers](#) who do *not* contract with your [health insurance](#) or [plan](#). Out-of-network co-payments usually are more than [in-network co-payments](#).

Out-of-Network Provider (Non-preferred Provider)

A [provider](#) who doesn't have a contract with your [plan](#) to provide services. If your [plan](#) covers [out-of-network](#) services, you'll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Out-of-Pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the [plan](#) will usually pay 100% of the [allowed amount](#). This limit helps you plan for healthcare costs. This limit never includes your [premium](#), [balance-billed](#) charges or healthcare your [plan](#) doesn't cover. Some [plans](#) don't count all of your [co-payments](#), [deductibles](#), [co-insurance](#) payments, [out-of-network](#) payments or other expenses toward this limit.



Physician Services

Healthcare services a licensed medical physician, including an MD (Medical Doctor) or DO (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain healthcare costs. Also called "health insurance plan," "policy," "health insurance policy" or "[health insurance](#)."

Preauthorization

A decision by your health insurer or [plan](#) that a healthcare service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called "prior authorization," "prior approval" or "precertification." Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your [health insurance](#) or [plan](#) will cover the cost.

Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the [plan's formulary](#) uses "tiers" (levels), [prescription drugs](#) are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each "tier" of covered [prescription drugs](#).

Prescription Drugs

Drugs and medications that, by law, require a prescription.

Preventive Care (Preventive Service)

Routine healthcare, including [screenings](#), check-ups and patient counseling, to prevent or discover illness, disease or other health problems.

Primary Care Physician

A physician, including an MD (Medical Doctor) or DO (Doctor of Osteopathic Medicine), who provides or coordinates a range of healthcare services for you.

Primary Care Provider

A physician, including an MD (Medical Doctor) or DO (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse [specialist](#) or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates or helps you access a range of healthcare services.

Provider

An individual or facility that provides healthcare services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility and [rehabilitation](#) center. The [plan](#) may require the provider to be licensed, certified or accredited as required by state law.

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.

Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain healthcare services. In many health maintenance organizations (HMOs), you need to get a referral before you can get healthcare services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

Rehabilitation Services

Healthcare 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.

Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is *not* the same as “skilled care services,” which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a healthcare professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

Summary Plan Description (SPD)

The [plan](#) document, which describes what benefits the [plan](#) provides and how it operates. It provides information on when an employee can begin to participate in the [plan](#), how to enroll dependents and how to file a [claim](#) for benefits.

Taft-Hartley Trust Fund

A collectively bargained, self-funded, employee benefit [plan](#) maintained by more than one employer, usually within the same or related industries, and a labor union.

UCR (Usual, Customary and Reasonable)

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](#).

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](#).

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500

Co-insurance: 20%

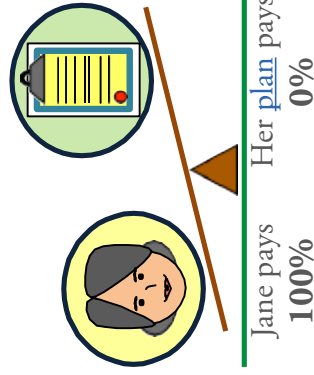
Out-of-Pocket Limit: \$5,000

January 1st

Beginning of Coverage Period

December 31st

End of Coverage Period



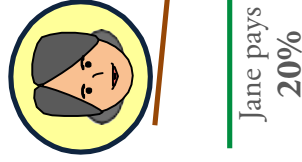
Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0



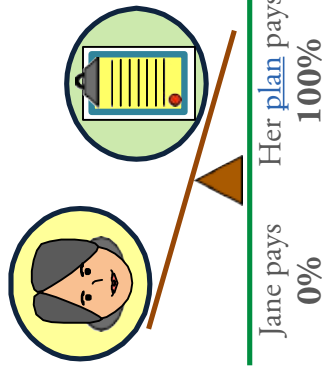
Jane reaches her \$1,500 deductible; co-insurance begins

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: \$125

Jane pays: 20% of \$125=\$25

Her plan pays: 80% of \$125=\$100



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered healthcare services for the rest of the year.

Office visit costs: \$125

Jane pays: \$0

Her plan pays: \$125