GLOSSARY OF TERMS AND ACRONYMS

ACA (Affordable Care Act) - signed under the title of The Patient Protection and Affordable Care Act, the law included multiple provisions that would take effect over a matter of years, including the expansion of Medicaid eligibility, the establishment of health insurance exchanges and prohibiting health insurers from denying coverage due to pre-existing conditions.

Ancillary Products – additional health insurance products (such as vision, life, or dental insurance) that may be added to a medical insurance plan for an additional fee.

Balance Billing – if a member uses an out-of-network provider they may be billed the difference between what the insurance carrier covers and the fee the doctor or hospital normally charges.

Capitation - method of compensation sometimes employed by health insurance companies, in which payment is made to a healthcare provider on a per-patient rather than a per-service basis. For example, under capitation an HMO doctor may be paid a fixed amount each month to serve as the primary care physician for a specific number of HMO members assigned to his or her care, regardless of how little or how much care each member needs.

Certificate of Credible Coverage – document disclosing information related to a member's prior health coverage. It must be issued automatically and free of charge when a member loses coverage under the plan.

Civil Union – a legal relationship between two persons, of either the same or opposite sex, recognized by the Illinois Religious Freedom Protection and Civil Union Act.

Claim – a formal request to an insurance company asking for a payment based on the terms of the insurance policy. Insurance claims are reviewed by the company for their validity and then paid out to the insured or requesting party (on behalf of the insured) once approved.

COBRA (Consolidated Omnibus Budget Reconciliation Act) – federal law that provides continuing coverage of group health benefits to employees and their families when certain qualifying events occur. COBRA covers health plans maintained by employers with more than 20 employees.

Coinsurance – the share of costs in a given plan between a member and the insurance company after the deductible has been met. It is expressed in percentages, for example 80% coinsurance means the insurance carrier will pay 80% of remaining costs and the member will pay 20% of costs until the out-of-pocket maximum has been met.

Community Rates – applies to 2014 ACA compliant plans. Premiums rates can only be based on family size, geographic rating area, age, and tobacco usage. Rates can no longer be increased based on claims experience.

Composite Rates – applies to some pre ACA compliant group plans. Premiums are not age or gender rated. Employees pay the same amount depending on coverage tier (i.e., EE only, EE+CH, EE+SP or FAM).

Deductible – The amount the member has to pay for out-of-pocket for expenses before the insurance company will cover the remaining costs.

Copayment – a specified dollar amount that the member is required to pay towards a covered service, including office visits, emergency room visits and prescription drugs.

Effective Date of Coverage – the date that coverage begins, assuming premium has been paid. This date can also represent the date a change in coverage took effect.

Employer Wage & Tax Statement - also called a UI 3/40 form. An employer tax reporting statement submitted to the applicable governmental agency to establish and report the employer's tax responsibilities.

Evidence of Insurability – a statement of medical history and related information which is used to determine whether an applicant will be approved for coverage.

Exclusions – a provision within the insurance policy that does not offer coverage for certain services, procedures and/or medical equipment.

Explanation of Benefits (EOB) – a form created for members when a health care benefits claim is processed by the carrier. The EOB displays the expenses submitted by the provider and shows how the claim was processed.

Formulary – a list of drugs covered under the health plan. The list is designed to provide the member and his/her physician with the most safe, effective drugs at the most reasonable cost.

Grace period – a specified period following the date a premium payment is due.

Health Savings Account (HSA) – a tax-advantaged medical savings account. Member must be enrolled in a high-deductible health plan (HDHP). Contributions are made into the account by the individual and/or the individual's employer and are limited to a maximum amount each year. The money can be used to pay for qualified medical expenses.

HIPAA (Health Insurance Portability and Accountability Act of 1996) – legislation mandating specific privacy rules and practices for medical care providers and health insurance companies, designed to protect the privacy and identity of healthcare consumers.

Illinois State Continuation – protects individuals who lose their group health insurance coverage with an employer group of any size due to termination of employment or reduction in hours. Most often applies to employers with less than 20 total employees.

In-Network Provider – a physician, hospital or other health care provider that has a written agreement with the carrier and provides services based on negotiated fees. Generally, using an in-network provider will save the member money in the form of copayments, lower deductibles and a higher reimbursement level.

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

Open Enrollment Period – a time period during which eligible persons or eligible employees may opt to sign up for coverage under the health insurance plan.

Out-of-network Provider – a doctor, hospital, or other health care entity that is not part of an insurance plan's network. For medical services provided by non-participating providers, the member may be responsible for higher out of pocket cost and can be balanced billed.

Out-of-pocket Maximum – the most a member will have to pay for covered services in a play year through deductible and coinsurance before the insurance plan begins to pay 100%.

Per-Occurrence Deductible (POD) – applies to Blue Cross Blue Shield ACA-Compliant plans. Certain services (emergency room/inpatient/outpatient surgery) are subject to a per occurrence deductible. The member's total claim will first be subject to the POD; the remaining amount will then be subject to the plan deductible and coinsurance. All charges will apply to the Out of Pocket Maximum.

Preexisting Condition – means any disease, illness, sickness or condition for which medical advice, diagnosis, care or treatment was received or recommended by a physician.

Preventive Services – routine health care that includes check-ups, patient counseling and screenings to prevent illness, disease and other health related problems.

Primary Care Physician (PCP) – a physician, such as a family practitioner or internist who is chosen by a member to provide routine medical and preventive care, and treatment for common illnesses. The PCP is also responsible for providing HMO referrals to specialists.

Referral – if a PCP is unable to provide care to the HMO member, he/she will provide a referral to a specialist for ongoing treatment. Each specialist referral is authorized for a specific number of visits or timeframe. If an HMO member goes to a physician other than their PCP without a referral, the carrier will not make any payment on the claim.

SBC (Summary of Benefits and Coverage) – requires that all carriers, employers and self-insured health plans provide members with a uniform summary of their benefits and coverage. SBCs must be provided to members during specific time periods. Visit the ACA section of this manual for further details.

Voluntary Benefits – insurance products that employees may chose to purchase through their employer. The employer does not contribute towards the cost of the premium.

ACRONYM LIST

ACA	Affordable Care Act
ACH	Automated Clearing House
AD&D	Accidental Death and Dismemberment
AOR	Agent of Record
AV	Actuarial Value
BOR	Broker of Record

CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act (Federal Act)
CPT	Current Procedural Terminology (Procedure Codes)
DME	Durable Medical Equipment
DOB	Date of Birth
DOL	U.S. Department of Labor
EAP	Employee Assistance Program
EFT	Electronic Funds Transfer
EHB	Essential Health Benefits
EOB	Explanation of Benefits
EOI	Evidence of Insurability
ERISA	Employee Retirement Income Security Act
FMLA	Family Medical Leave Act
FSA	Flexible Spending Arrangement
GI	Guaranteed Insurability Benefit (Life)
HDHP	High Deductible Health Plan
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability & Accountability Act
HMO	Health Maintenance Organization
HRA	Health Reimbursement Arrangement
HSA	Health Savings Account
ICD-9	International Classification of Diseases (Diagnosis codes)
IPA	Independent Practice Association
IRA	Individual Retirement Account
IRS	Internal Revenue Service
LTC	Long Term Care
MLR	Medical Loss Ratio

MSP	Medicare Secondary Payer
MV	Minimum Value
NAIC	National Association of Insurance Commissioners
NPI	National Provider Identifier
OEP	Open Enrollment Period
OTC	Over the Counter
PCP	Primary Care Physician
PMPM	Per Member Per Month
POA	Power of Attorney
PPO	Preferred Provider Organization
QHP	Qualified Health Plan
SBC	Summary of Benefits and Coverage
SEHIRA	Small Employer Health Insurance Rating Act
SEP	Special Enrollment Period
SHOP	Small Business Health Options Program
SSA	Social Security Administration
TPA	Third Party Administrator
TRICARE	Health insurance program for military personnel
U & C	Usual and Customary
WPHCP	Women's Principal Health Care Provider