Health Care Glossary

Florida Blue
In the pursuit of health®

Health care terms can sometimes be confusing.

We're here to help make sense of these terms, so you can better understand them and make the best decisions for your health care.

These terms and descriptions have been simplified to make them easier to understand, so they may differ from the contract or policy that you receive.

A

Accidental Death Benefit: The payment due to the beneficiary of an accidental death insurance policy.

Admission: Overnight or inpatient admittance to an acute care general hospital, skilled nursing facility, birthing center or mental health facility.

Admitting Privileges: The right or privilege granted to a physician to admit patients to a particular hospital.

Adult Dental Benefits: These benefits may include Preventive, Basic and Major dental services for adults (ages 19 or older), such as oral exams, x-rays, fillings, extractions and more.

Adult Vision Benefits: These benefits may include routine vision services for adults (age 19 or older), such as eye examinations, prescription eyeglasses and contact lenses.

Affordable Care Act (ACA): The health care reform law was signed on March 23, 2010 and brings a lot of health care changes to consumers, providers and insurance companies. It dictates who must buy insurance, how insurance will be sold and what health benefits have to be included in a health plan.

Agent: A salesperson licensed to sell insurance coverage. This person may present different insurance products offered by multiple insurance companies.

Allowed Amount: What you pay for medical care is based on an "allowed amount". This is a lower amount that Florida Blue has negotiated with in-network providers. A provider who is not in your health plan's network may charge more than the allowed amount and you may have to pay the difference.

Ambulatory or Outpatient Surgical Center: A licensed facility (pursuant to Chapter 395 of the Florida Statutes or a similar applicable law of another state) that primarily provides elective outpatient (same day) surgical care.

Appeal: A request for your health insurer or plan to review a claims' decision or a grievance again.

At-Home Recovery: Short-term at home assistance with daily living activities (bathing, personal hygiene, dressing and more) if you are recovering from an illness, injury or surgery.

B

Balance Billing: Out-of-network providers may charge more than our Allowed Amount and can "balance bill" you for this extra amount. When you use in-network providers, you never pay more than the Allowed Amount for covered services.

Basic Dental Care: Refers to fillings, extractions and anesthesia.

Benefit: The services that are covered by your insurance. For example, depending on your plan, benefits can include physician visits, hospital stays, prescription drug coverage and more.

Brand Name Drug: A prescription drug that is marketed under a patent name by the manufacturer who developed the drug. These drugs may be included in Florida Blue's Medication Guide (list of covered drugs). Drugs that are covered vary by health plan.

C

Calendar Year/Benefit Period: Your benefit period is the timeframe when your health plan's benefits start and end. This is usually based on a calendar year: January 1 through December 31.

Catastrophic Illness: Very serious health problems that can be life threatening or cause lifelong disability. Without appropriate health care coverage, such conditions could be extremely costly and cause financial hardship.

Certificate of Creditable Coverage: A document that shows proof of prior insurance coverage.

Certificate of Coverage: The document that outlines your specific policy and all the benefits and coverage provisions, including what is, and what is not, covered as well as dollar limits.

Child Health Insurance Program (CHIP): CHIP provides low-cost health insurance coverage for children of families who earn too much income to qualify for Medicaid coverage, but can't afford to purchase private health insurance. CHIP is a state and federal partnership program that works closely with Medicaid.

Claim: A request to the insurance company to pay for services by a health care provider.

78778-0614

Health Care Glossary

Florida Blue
In the pursuit of health®

C

COBRA: Federal law that allows you to continue your group health insurance coverage from your employer (20 or more employees) for up to 18 months, 29 months if disabled, after your group coverage ends due to death, divorce, or termination of eligibility in certain situations.

Coinsurance: This is the percentage (%) that you may pay for covered health services after you meet the plan deductible. It is also called 'cost sharing'. You pay the plan deductible first, then coinsurance (%) may apply.

Copay: A flat fee (for example, $15) that you may pay for covered health care services.

Covered Services or Coverage: The services that are eligible to be paid for by your health plan are called 'covered services'.

D

Deductible: This is the dollar amount that you must pay each year before insurance begins to pay for certain health care services. You pay the plan deductible first, then coinsurance (%) may apply.

Dependent: Refers to a spouse, domestic partner, if applicable, or eligible child (by birth, adoption or legal guardianship) of the contract holder.

Doctor Office Visit: Refers to a visit to a licensed physician's office.

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. Your plan may require that these be obtained from a contracted and participating supplier (See Exclusive Provider Organization).

E

Effective Date: Refers to the date your insurance coverage actually begins. You are not covered and cannot begin to use your health plan benefits, until the effective date.

Emergency Room: The department of a hospital responsible for providing immediate medical or surgical care.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Endorsement: An amendment changing language in your contract, such as adding or excluding coverage for certain benefits or modifying administrative processes (e.g., eligibility requirements, claims).

Essential Health Benefits: Starting October 1, new health plans must include coverage for certain health care services known as 'essential health benefits' such as: preventive care, emergency services, hospitalization, prescription drugs, maternity and newborn care, pediatric dental and vision care, lab services and more. Coverage for the new plans starts January 1, 2014.

Exclusions: Medical items or services that are not covered by your health plan.

Exclusive Provider Organization (EPO): An EPO is a network of medical providers that must be used for certain health care services or supplies in order to be covered by a health plan (except emergency services).

Explanation of Benefits (EOB): A written explanation of benefits regarding a claim. This is not a bill, but a description of what your plan will pay for covered services and what you are responsible for paying.

F

Face Amount: For Critical Illness policies, this refers to the amount of coverage purchased.

F

Federal Poverty Level (FPL): A benchmark or standard that the federal government uses to measure income. Generally, families with incomes up to four times the FPL may qualify for a subsidy.

Florida Blue HMO: Florida Blue HMO is a trade name of Health Options, Inc., an HMO subsidiary of Blue Cross and Blue Shield of Florida. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

G

Generic Drug: A prescription drug that has the same active ingredients found in brand name prescription drugs. These drugs may be included on Florida Blue's Medication Guide (list of covered drugs) and the drugs that are covered vary by health plan. Generic prescription drugs are approved by the Federal Drug Administration and usually cost less than the brand name drug.

Grievance: A complaint that you communicate to your health plan.

Guaranteed Health Coverage: For plans with effective dates of January 1, 2014 and later, no one can be turned down for health coverage because of his or her medical history. Everyone can get a health plan.

H

Health Maintenance Organization (HMO): An alternative health care financing and/or delivery organization that either provides directly, or through arrangements made with other persons or entities, comprehensive health care coverage and benefits or services, or both, in exchange for a prepaid per capita or prepaid aggregate fixed sum. While some HMOs are similar, not all HMOs operate or are organized in the same way. For example, an HMO can be organized and operate as a staff model, a group model, an IPA model or a network model.

78778-0614

Health Care Glossary

Florida Blue
In the pursuit of health®

H

Health Options, Inc.: An HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc., (D/B/A Florida Blue HMO), an Independent Licensee of the Blue Cross and Blue Shield Association.

Health Statement: A summary of claims processed for the prior month. Also, referred to as an Explanation of Benefits (EOB), this is not a bill, but a description of how much your plan has paid for covered services and what you may be responsible for paying.

Health Savings Account (HSA): This is a tax-exempt trust or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you incur (See IRS Publication 969). You must be an eligible individual to qualify for an HSA, including enrollment in a qualified high deductible health plan. Florida Blue offers qualified health plans.

Hospital and ER Physician Services: Refers to the services performed by a licensed physician at a hospital or emergency room department of a hospital.

Habilitation Services: Health Care Services that are short-term and help a person to acquire or attain an age-appropriate bodily function necessary to participate in activities of daily living.

Home Health Care: Health care services a person receives at home.

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

I

In-Network: A group of physicians, hospitals and other health care providers that has agreed to lower negotiated charges (referred to as Allowed Amount). For the lowest out-of-pocket costs, choose providers who are in-network for your health plan. **Indemnity:** A type of health plan that reimburses the patient with a lump sum payment or for expenses incurred.

Independent Clinical Lab: A laboratory, properly licensed pursuant to Chapter 483 of the Florida Statutes, or a similar applicable law of another state, which is not part of a hospital or physician facility, that performs procedures such as urinalysis, blood chemistry tests, blood cell counts, Pap tests, HIV tests and more, to help diagnose and/or treat medical conditions.

Individual Health Insurance Policies: Health insurance coverage that is not provided through an employer or group coverage. These policies are for self-employed individuals or individuals whose employer does not offer group health insurance.

Inpatient Services: You receive inpatient services when you are admitted to a facility overnight as a patient for medically necessary care or treatment by a licensed physician.

L

Limitations: Refers to the limit, if any, on the amount of benefits your insurance will pay on particular covered expenses.

M

Mail Order Drug: A program that allows you to purchase prescription drugs by mail and have them shipped directly to your home. Generally medications available via mail order are for chronic conditions requiring extended use. Ordering a 3 month supply by mail often costs less than buying them monthly at a retail pharmacy.

Major Dental Care: Refers to root canals, periodontal services (scaling and root planning), dentures (complete and partial), crowns and bridges.

Marketplace: This is the government's health insurance Marketplace where individuals can shop and compare health plans online or in person. Your agent can guide you through Florida Blue health plans available through the Marketplace.

Metal Plans: The Marketplace will offer four different levels of health insurance plans (called 'metal' plans because their names are Bronze, Silver, Gold and Platinum). They will offer similar health benefits, with different out-of-pocket costs and Premiums.

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.

Medicare Disability: The Medicare coverage for people aged 18 to 64 who collect or qualify for Social Security Disability Income. Disabled individuals are unable to work for at least a year because of a qualifying physical or mental impairment or are expected to die from an impairment.

Medication Guide: A list of prescription drugs that may be covered by your health plan.

Mental Health Services: Refers to the care or treatment of emotional or behavioral conditions by a licensed physician or mental health professional (also referred to as Behavioral Health Services).

N

Network: A group of physicians, hospitals and other health care providers that has agreed to lower negotiated charges (referred to as Allowed Amount). You typically pay less money when you visit providers in your plan's network.

Non-Preferred Brand Name Drugs: A category of brand name prescription drugs that typically cost more to purchase. Often a drug in this category has a generic drug equivalent or there is a similar brand name drug available in a different category.

78778-0614

Health Care Glossary

Florida Blue
In the pursuit of health®

Open Enrollment: The period of time set up to allow you to choose from available individual health plans. However, there are Special Enrollment Periods for certain life events.

Out-of-Pocket Maximum: The out-of-pocket maximum is the most you pay for covered health care services during your plan's calendar year. All of your covered expenses go toward this maximum. Once you reach the maximum, your plan pays 100% for covered services.

Out-of-Network: Refers to health care providers that are not contracted or participating providers for your health plan (i.e., BlueOptions, BlueCare, BlueSelect). These providers may charge full price for medical care, and you may be responsible for the difference in their charge and the Allowed Amount (See Balance Billing).

Outpatient Services: Refers to the medical care or treatment received in a doctors' office, hospital or facility during a one-day (not overnight) procedure or visit. It includes diagnostic services like X-rays, ultrasounds and CAT scans.

Patient Protection and Affordable Care Act (PPACA): The health care reform law was signed on March 23, 2010 and brings a lot of health care changes to consumers, providers and insurance companies. Commonly referred to as 'The Affordable Care Act (ACA)' or 'Obamacare', it dictates who must buy insurance, how insurance will be sold and what health benefits have to be included in a health plan.

Pediatric Dental: Refers to health plans that include routine dental services for children (up to age 19), such as oral exams, X-rays, fillings, extractions and more.

Pediatric Vision: Applies to health plans that include routine vision services for children (up to age 19), such as eye examinations, prescription eyeglasses and contact lenses.

Physician: Any person licensed as a doctor, such as Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), or Doctor of Optometry (O.D.).

Physician Services: Refers to the services and treatment provided by a licensed physician, whether at a doctor's office, hospital or other medical facility.

Plan Type: Refers to the kind of health care plan (e.g. PPO, HMO, EPO).

Preferred Brand Name Drugs: A category of Brand Name prescription drugs that are less expensive than non-preferred brand name drugs.

Preferred Provider Organization (PPO): PPO stands for Preferred Provider Organization. This type of health insurance plan provides comprehensive medical coverage to members with the flexibility to see any health care provider, whether in- or out-of-network (Some exceptions may apply. See Exclusive Provider Organization).

Premium: Your premium is the regularly scheduled amount of money you must pay to keep your insurance in effect.

Prescription Drugs: Any medicinal substance, remedy, vaccine, biological product, Drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription".

Preventive Dental Care: Refers to oral exams, X-rays, cleanings and child fluoride treatment.

Preventive Medical Care: Medical care that focuses on preventing health problems from occurring and diagnosing health conditions early for greater chances of recovery. Care can include wellness exams, vaccines, routine health screenings and more. Check your plan benefits to see which services may be provided at no cost to you.

Pre-existing Conditions/Guaranteed Coverage: For plans with effective dates of January 1, 2014 and later, no one can be turned down for health coverage because of his or her health history. Everyone can get a health plan.

Primary Care Physician (PCP): A physician you choose to monitor your overall health care needs. This physician makes sure you get the care you need to stay healthy, and often refers you (though not required) to specialist physicians if you require specialized care.

Prior Authorization: To ensure quality care and to help you get the most value from your plan benefits, certain medical services will **require that you get an approval** from Florida Blue prior to receiving care. This "prior authorization" will determine if the service or location of treatment will be covered by your health plan. If those services are not authorized ahead of time, you may be responsible for paying the entire cost (except in an emergency).

Qualified Medical Expenses (QMEs): QMEs are out-of-pocket medical expenses that qualify for tax-free withdrawals from a Health Savings Account (HSA). Examples include amounts you pay for doctor visits, hospital care, prescription drugs and more. See IRS Publication 502 for a complete list.

78778-0614

Health Care Glossary

Florida Blue
In the pursuit of health®

R

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.

Recurrent Benefit: For Critical Illness product, an additional benefit payout for the recurrence or reoccurrence of an illness. There are two aspects to the Recurrent Benefit, one for a different critical illness (recurrence) and reoccurrence for a second time.

Rehabilitation Services: Services rendered for the purpose of restoring function lost due to illness, injury or surgical procedures including but not limited to Cardiac Therapy, pulmonary rehabilitation, Occupational Therapy, Speech Therapy, Physical Therapy and Massage.

S

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Skilled Nursing Facility: A facility that offers 24-hour medical and custodial care. Some offer specialized care for specific conditions. Your stay at a skilled nursing facility can be temporary or long-term.

Special Enrollment: A period of time when individuals with special qualifying events (e.g., marriage, birth of a child, loss of employment) are allowed to enroll in or modify a health plan. The qualifying event will dictate the actual enrollment period, which is usually 60 days from the date of event.

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.

Specialty Drug: Refers to a FDA-approved Prescription Drug that has been designated, solely by us, as a Specialty Drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty Drugs may be Provider administered or self-administered and are identified with a special symbol in the Medication Guide.

Subscriber: An individual who consistently meets all applicable eligibility requirements and who is actually enrolled under the contract other than as a dependent. This can also be referred to as contract holder or member.

Subsidy or Premium Tax Credit: If you qualify, the government may help you pay part of your monthly health insurance bill. The amount depends on things like your taxable household income, your family size and ages and where you live. These lower costs are handled with a tax credit called the Advance Premium Tax Credit. But these tax credits can be used right away to lower your monthly premium costs. It does not pay for doctor or hospital visits, prescriptions, etc. You still pay for some of those costs; however, financial assistance may be available to help qualifying individuals pay for out-of-pocket health care costs.

Substance Dependency: A condition where a person's alcohol or drug use injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.

Summary of Benefits and Coverage (SBC): The SBC is a document that all insurance companies are required to provide consumers as a result of health care reform. It is a standardized summary of health plan benefits and coverage, including covered benefits, cost sharing examples, and coverage limitations and exceptions. The purpose of the SBC is to help you understand similar features of each plan, make it easier to compare your options, and ultimately, choose a plan that is right for you or your family.

T

Term: Refers to the time period that coverage is in effect.

Tobacco Usage for 6 months: The use of any tobacco (i.e., cigarettes, cigars, pipes, etc.) regularly, which is defined as four or more times per week on average, excluding religious or ceremonial uses.

U

Urgent Care Centers: An urgent care center offers medical services by physicians, nurses and X-ray technicians in a non-hospital emergency room location. Usually appointments are not necessary and patients can be seen on a walk-in basis. Urgent care centers are primarily for injuries and illnesses that require immediate care but not serious enough for an emergency room visit.

W

Waiver of Premium: A provision that continues Life insurance coverage without premium payments, if the insured becomes totally disabled.

78778-0614