HOPEHEALTH
WITH HOPE, ALL THINGS ARE POSSIBLE

Affordable Care Act Glossary of Terms

Appeal
An appeal is the action you can take if you disagree with a coverage or payment decision by your health plan. You can appeal if your health plan denies one of the following:

- Your request for a health care service, supply or prescription drug that you think you should be able to get.
- Your request for payment for health care or a prescription drug you already got.
- Your request to change the amount you must pay for a prescription drug.
- You can also appeal if you are already getting coverage and your plan stops paying.

Co-Insurance
An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Co-insurance is usually a percentage (for example, 20%).

Copayment
An amount you may be required to pay as your share of the cost for a medical service or supply like a doctor's visit, hospital outpatient visit or prescription drug. A copayment is usually a set amount rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.

Emergency Services
Evaluation of an illness, injury, symptom or condition so serious that a reasonable person would seek care right away and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your health coverage or plan does not pay for.

Explanation of Benefits (or EOB)
A summary of health care charges that your insurance company sends you after you see a provider or get a service. It is not a bill. It is a record of the health care you or individuals covered on your policy got and how much your provider is charging your insurance company.

Formulary
A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Hospital Outpatient Care
Care in a hospital that usually does not require an overnight stay.

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DO YOU HAVE QUESTIONS?

Appointments available in Manning, Kingstree, Timmonsville, and Florence.

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In-Network Co-Insurance
The percentage (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-Network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Network (also referred to as in-network)
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Out-of-Network
A provider who does not have a contract with your health insurer or plan to provide services to you. You will pay more to use them.

Out-of-Network Co-Insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-Pocket Maximum
The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. The out-of pocket maximum includes the yearly deductible and may also include any cost sharing you have after the deductible. For most health plans for 2014, the highest out-of-pocket maximum for an individual is $6,350 and $12,700 for a family. These numbers will rise in 2015.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment 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 is not a promise your health insurance or plan will cover the cost.

Premium
The periodic payment to an insurance company or a health care plan for health or prescription drug coverage.

Preventive Services
Routine health care that includes screenings, checkups, and patient counseling to prevent illnesses, disease or other health problems or to detect illness at an early stage, when treatment is likely to work best (this can include services like flu and pneumonia shots, vaccines, and screenings like mammograms, depression/behavioral health screenings or blood pressure tests depending on what is recommend for you).

Primary Care Provider
The doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many health plans, you must see your primary care doctor before you see any other health care provider.

Specialist
A physician specialist who 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.