

# Explanation of Common Terms

<b>Allowed Amount</b>	The amount paid by the plan after plan benefits are applied.
<b>Ambulatory Surgery Center (ASC)</b>	A facility (that is not licensed as a hospital) where surgeries that do not require hospital admission are performed.
<b>Billed Charge</b>	The provider's fees for the service performed before a discount is applied.
<b>Brand Name Medication</b>	A manufacturer assigns a brand name to a medication or drug, but it contains the same ingredients as a generic medication. Typically, brand name drugs are higher in cost as the company that named them needs to cover the costs of developing them, obtaining a patent, conducting clinical trials, and getting FDA approval. US patents for brand name medications have term limits, generally 20 years, and when the patent expires, other companies create generic versions of that medication.
<b>Bundle</b>	A bundle is an upfront, lump-sum cost for a package of medical services. It typically covers services related to a single clinical episode, including physician fees and facility costs for a specific episode. Bundled payments can eliminate pricing variation and promote simplified billing.
<b>Co-Insurance</b>	The portion of incurred medical expenses, usually a fixed percentage, that the patient must pay out-of-pocket. Co-Insurance is calculated based on the benefits outlined in the Summary Plan Description (SPD) and is typically applied after the patient's deductible has been satisfied.
<b>Co-Pay</b>	A flat fee a patient pays per a certain service or benefit, e.g. \$10 for an office visit. This fee is applied each time the patient receives the defined service and is not credited toward the maximum out-of-pocket expense provision.
<b>Deductible</b>	The amount over covered expenses that must be incurred and paid for by the patient before benefits are paid by the group health plan. The plan's family deductible may be an aggregate of all family members' charges or each family member's deductible may be tracked separately. Typically, participants must satisfy a new deductible each calendar year. In most cases, deductible along with co-insurance is applied to the maximum out-of-pocket expense provision of the patient's plan.
<b>Discount</b>	The difference between the amount charged by the provider and the amount the provider agreed to accept as payments in full. The Alliance is shifting its contracts away from discounts and towards Medicare-based contracts because discounts are not necessarily representative of savings. By contracting based on Medicare, The Alliance can better determine how costs compare across hospital systems.
<b>Durable Medical Equipment (DME)</b>	Any medical equipment used in the home to aid in a better quality of living, such as: wheelchairs (manual and electric), hospital beds, traction equipment, canes, crutches, walkers, kidney machines, ventilators, oxygen, monitors, pressure mattresses, lifts, nebulizers, etc.
<b>Explanation of Benefits</b>	Explanation of Benefits (EOB) is a statement produced by the Third Party Administrator (TPA) showing how a claim was processed.

<b>Fully Insured Employer</b>	Similar to an individual purchasing a private health insurance product, this is when employers purchase indemnity insurance to provide medical coverage to their employees and their families. Employers pay one fee regardless of how much healthcare is utilized.
<b>Generic Medication</b>	A generic medication or drug is called by its chemical name but contains the same ingredients as a brand name medication. Standard practice and most state laws require that a generic drug be generically equivalent to its brand name counterpart with the same active ingredients, strength, and dosage form – pill, liquid or injection. The generic drug also must be therapeutically equivalent – it must be the same chemically and have the same medical effect.
<b>Healthcare Consumerism</b>	The movement to get patients more engaged in healthcare by 1) interacting with the healthcare system like customers – where they use the information to make decisions and hold providers accountable for the services they receive and 2) recognizing their responsibility for self-care and lifestyle-related disease prevention.
<b>HIPAA</b>	Health Insurance Portability and Accountability Act of 1996 – establishes national standards for electronic healthcare transactions and national identifiers for providers, health plans, and employers. It also addresses security and privacy of health data.
<b>Hospitalist</b>	A physician that specializes in managing inpatient care. Can either be employed by the hospital or contracted by the hospital to provide care.
<b>Inpatient Care</b>	Medical care provided that results in an overnight stay.
<b>Out-of-Pocket Maximum</b>	The most a patient is required to pay for covered charges during a specific time period, often one year. It may or may not include the deductible. Family maximums may be an aggregate of all family members' coinsurance and/or deductibles or calculated separately.
<b>Pre-authorization and Pre-certification</b>	The process of approving services prior to charging to the health plan. This is defined by individual benefits plans.
<b>Primary Care Provider (PCP)</b>	A primary care provider (PCP) is the primary person patients see for their healthcare. Primary care providers help you stay healthy and make sure you get all the regular tests you need. They help you make decisions about your health because they know your family medical history. If you have ongoing health issues like asthma or diabetes, they provide regular treatment to keep it from getting worse. They also help you find other medical experts if you need them.
<b>Self-Insured Employer</b>	Employers who directly pay for their employees' medical expenses without purchasing a traditional indemnity insurance policy or HMO. TPAs process the medical claims and issue payments on the behalf of the employer.
<b>Specialist</b>	A physician specialist treats certain health conditions or specific parts of the body. Examples of specialists include cardiologists (who treat heart problems), oncologists (who treat cancer), orthopedists (who treat bone and muscle problems), and obstetricians (who treat people who are pregnant). A non-physician specialist is a provider who has extra training in a specific area of healthcare.
<b>Third Party Administrator (TPA)</b>	The company hired by our employer-member to administer their group healthcare plan. The TPA is responsible for applying plan provisions/payment of medical claims and answering benefit related questions.