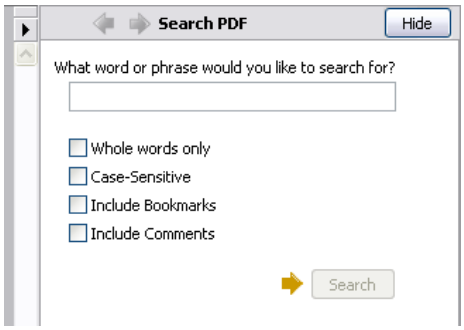
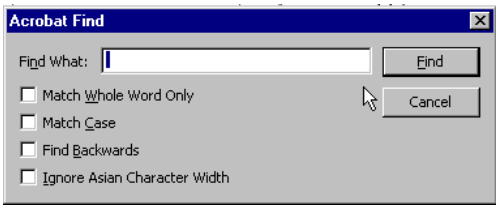
How to Search a PDF Document using Adobe Acrobat Reader

Adobe Acrobat Reader allows you to search for words or phrases in a PDF document while you are viewing it. To search for a word or phrase in a PDF document that you are *currently viewing*, do the following:

1. In the Acrobat toolbar (near the top of your web browser when you are viewing a PDF document), move your mouse over the binoculars and click on them.

2. Clicking on the binoculars activates the "find" feature. An "Acrobat Find" box will pop up.





3. Enter a word or phrase into the search field or the "Find What:" box and click on "Find".

Healthcare Reform Website Glossary

Access – A patient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their acceptability to the patient, availability of insurance, the location of health care facilities, transportation, hours of operation, affordability and cost of care.

Accreditation – Approval by an authorizing agency for institutions and programs that meet or exceed a set of pre-determined standards.

Activities of daily living (ADLs) – Activities performed as part of a person's daily routine of self-care such as bathing, dressing, toileting, and eating.

Actual Charge – The dollar amount a health care provider bills to a patient for a particular medical service or procedure.

Actuary – A mathematician working for a health insurance company responsible for determining what premiums the company needs to charge based in large part on claims paid verses amounts of premium generated. Their job is to make sure a block of business is priced to be profitable.

Acute Care – Hospital care given to patients who generally require a stay of several days that focuses on a physical or mental condition requiring immediate intervention and constant medical attention, equipment and personnel.

Administrative Costs – Costs related to activities such as utilization review, marketing, medical underwriting, commissions, premium collection, claims processing, insurer profit, quality assurance, and risk management for purposes of insurance.

Admitting Privileges – The right granted to a doctor to admit patients to a particular hospital.

Advance Directive – A document that patients complete to direct their medical care when they are unable to communicate their own wishes due to a medical condition. In Ohio, do not resuscitate orders, living wills and durable powers of attorney are advance directives that are authorized by state law.

Advanced Practice Nurse (APN) – A registered nurse who is approved by the Board of Nursing to practice nursing in a specified area of advanced nursing practice. APN is an umbrella term given to a registered nurse who has met advanced educational and clinical practice requirements beyond the two to four years of basic nursing education that is required of all RNs. There are four types: 1) certified registered nurse anesthetist (CRNA); 2) clinical nurse specialist (CNS); 3) certified nurse practitioner (CNP); 4) certified nurse midwife (CNM).

Adverse drug event (error) – Any incident in which the use of medication (drug or biologic) at any dose, a medical device, or a special nutritional product may have resulted in an adverse outcome in a patient.

Adverse event – An injury resulting from a medical intervention that is not due to the underlying condition of the patient.

Adverse selection – Among applicants for a given group or individual health insurance program, the tendency for those with an impaired health status, or who are prone to higher-than-average utilization of benefits, to be enrolled in disproportionate numbers in lower deductible plans.

Aftercare – Services following hospitalization or rehabilitation, individualized for each patient's needs. Aftercare gradually phases the patient out of treatment while providing follow-up attention to prevent relapse.

Agent – Licensed salesperson who represents one or more health insurance companies and presents their products to consumers.

Allied health personnel – Specially trained and often licensed health workers other than physicians, dentists, optometrists, chiropractors, podiatrists and nurses. The term is sometimes used synonymously with paramedical personnel, which are all health workers who perform tasks that must otherwise be performed by a physician, or health workers who do not usually engage in independent practice.

Allopathic – One of two schools of medicine that treat disease by inducing effects opposite to those produced by the disease. The other school of medicine is osteopathic.

Allowable costs – Charges for services rendered or supplies furnished by a health provider which qualify as covered expenses for insurance purposes.

Alternative delivery – An alternative to traditional inpatient care system such as ambulatory care, home health care and same-day surgery.

Alternative medicine – Treatment procedures that are not supported by mainstream medicine, often due to lack of supporting experimental data.

Ambulance restocking – The practice of a hospital replenishing certain drugs and supplies used by an ambulance service during transport of a patient to the hospital.

Ambulatory care – Care given to patients who do not require overnight hospitalization.

Ambulatory payment classification (APC) – Groups or groupings of medical procedures and services used as a basis for reimbursement under the Medicare outpatient prospective payment system (OPPS).

Ambulatory setting – An institutional health setting in which organized health services are provided on an outpatient basis, such as a surgery center, clinic or other outpatient facility. Ambulatory care settings also may be mobile units of service (mobile mammography, MRI).

Americans with Disabilities Act (ADA) – A federal law that prohibits employers of more than 25 employees from discriminating against any individual with a disability who can perform the essential functions, with or without accommodations, of the job that the individual holds or wants.

Ancillary – A term used to describe additional services performed related to care, such as lab work, X-ray and anesthesia.

Anti-kickback statute – A federal law that prohibits the paying or receiving of remuneration in exchange for the referral of patients or business paid by a federal health care program.

Antitrust – A situation in which a single entity, such as an integrated delivery system, controls enough of the practices in any one specialty in a relevant market to have monopoly (the power to increase prices).

Any willing provider – A term used to describe legislation requiring a health plan to accept on its provider panels every physician, hospital or other practitioner that wants to participate in the health plan's products.

Approved Charge – The dollar amount on which an insurance company bases its payments and your co-payments. This may be less than the actual charge.

Approved health care facility or program – A facility or program that is licensed, certified or otherwise authorized pursuant to the laws of the state to provide health care and that is approved by a health plan to provide the care described in a contract.

Average length of stay (ALOS) – A standard hospital statistic used to determine the average amount of time between admission and departure for patients in a diagnosis related group (DRG), an age group, a specific hospital or other factors.

Association – A group. Often, associations can offer individual health insurance plans specially designed for their members.

Bad debt – Charges a hospital considers to by uncollectible in the relatively near future. Generally, a bad debt is recognized after a hospital has attempted and failed to collect an account receivable.

Balance billing – A provider's billing of a covered person directly for charges above the amount reimbursed by the health plan. This may or may not be allowed, depending upon the contractual arrangements between the parties.

Beneficiary – A person who receives benefits of any insurance plan or policy.

Benefit – Amount payable by the insurance company to a claimant, assignee, or beneficiary when the insured suffers a loss.

Benefit Maximum – The most a health insurance policy will pay for a specified loss or covered service. The benefit can be expressed as either a period of time, a dollar amount or a percentage of the approved amount. Benefits may be paid to the policyholder or a third party.

Benefit Period – The time for which benefit payments from an insurance policy are available. A policy may include different benefit periods for different kinds of treatment or services.

Biometric Screenings – Health screen of individual's biometrics requiring blood draw. Screen can cover a number of areas but often includes cholesterol, glucose, blood pressure, weight and height. Assistance interpreting the results is often included.

Board certified – A clinician who has passed the national examination in a particular field. Board certification is available for most physician specialties, as well as for many allied medical professions.

Brand-name drug – Prescription drugs marketed with a specific brand name be the company that manufactures it, usually the company which develops and patents it. When patents run out, generic versions of many popular drugs are marketed at lower cost be other companies. Check you insurance plan to see if coverage differs between brand-name and their generic twins.

Broker – Licensed insurance salesperson who obtains quotes and plan information from multiple sources for clients.

Capitation – Capitation represents a set dollar limit that you or your employer pay to a health maintenance organization (HMO), regardless of how much you use (or don't use) the services offered by the health maintenance providers.

Captive Insurance – A wholly owned subsidiary of a business or other legal entity, including a group of hospitals or trade associations, that is formed to insure risk. A captive is a form of self-insurance that has assumed the formalities of an insurance company.

Carrier – The insurance company or HMO offering a health plan.

Case Management – Case management is a system embraced by employers and insurance companies to ensure that individuals receive appropriate, reasonable health care services. Often used for patients with specific diagnosis and those requiring high-cost or extensive health care services.

Case mix index – A measure of relative severity of medical conditions of a hospital's patients.

Certificate Holder – An employee or other insured named under a group health insurance policy.

Certificate of Insurance – The printed description of the benefits and coverage provisions forming the contract between the carrier and the customer. Discloses what is covered, what is not, and dollar limits.

Certificate of Need (CON) – A designations that hospitals had to obtain from the Ohio Department of Health (ODH) to authorize an activity such as constructing or modifying hospitals, purchasing certain medical equipment or providing new health care services.

This process was gradually phased out for most acute care hospital activities from 1995 through 1998 and replaced with quality standards.

Charity care – Health care services provided free of charge or at a substantial discount, based on individual income and need.

Children's Health Insurance Program (CHIP) – A state-administered program funded partly by the federal government that allows states to expand health coverage to the uninsured, low-income children not eligible for Medicaid. Also called the State Children's Health Insurance Program (SCHIP).

Chronic Condition – A continuous or prolonged illness or condition. Examples: asthma, diabetes, varicose veins.

Chronic Disease Management – A coordinated system of preventive, diagnostic and therapeutic measures intended to provide cost-effective, quality healthcare for a patient population who have or are at risk for a specific chronic illness or medical condition.

Claim – A request for payment for services provided by a health care professional.

COBRA – Federal law requiring that workers who end employment for specified reasons have the option of purchasing group insurance through the employer for a limited period of coverage (usually 18 months, but in some cases 29 months or 36 months). For more information, please visit The Department of Labor: http://www.dol.gov/dol/topic/health-plans/cobra.htm

Co-insurance – A specified dollar amount or percentage of covered expenses which an insurance policy or Medicare requires a beneficiary to pay toward eligible medical bills.

Community benefit – The economic and social benefit provided by hospitals to the surrounding communities, and care provided for patients who may not be able to pay all or any of their bills.

Community rating – Setting insurance rates based on the average cost of providing health services to all people in a geographic area without adjusting for each individual's medical history or likelihood of using medical services.

Conditionally Renewable – An insurance policy that the company will renew with each premium payment, as long as you meet certain conditions.

Coordination of Benefits (COB) – Provisions and procedures used by insurers to avoid duplicate payments when a person is covered by more than one policy.

Co-payment (co-insurance) – A specified dollar amount or percentage of covered expenses which in insurance policy or Medicare requires a beneficiary to pay toward eligible bills.

Coverage – All or part of an individual's health care costs, paid either by insurance or by the government.

Covered Services – Services for which an insurance policy will pay.

Credentialing – The process of reviewing a practitioner's academic, clinical and professional ability as demonstrated in the past to determine if criteria for clinical privileges are met.

Credit for Prior Coverage – This is something that may or may not apply when you switch employers or insurance plans. A pre-existing condition waiting period met while you were under an employer's (qualifying) coverage can be honored by your new plan, if any interruption in the coverage between the two plans meets state guidelines.

Critical access hospital (CAH) – A federal designation under which hospitals receive cost-based reimbursement for Medicare services. Hospitals must meet certain criteria, such as size, length of stay and proximity to other facilities.

Deductible – The amount an individual must pay for health care expenses before insurance (or a self-insured company) covers the costs. Often, insurance plans are based on yearly deductible amounts.

Denial of Claim – Refusal by an insurance company to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional.

Dependents – Spouse and/or unmarried children (whether natural, adopted or step) of an insured.

Dependent Worker – A worker in a family in which someone else has greater personal income.

Diagnostic related group (DRG) – A classification system that groups patients by common characteristics requiring treatment.

Disability Medical Assistance – A state administered program that provides limited medical assistance to persons who are medication-dependent and ineligible for any category of Medicaid. There is no federal funding or federal regulation of this program.

Discharge planning – The evaluation of patients' health needs for appropriate care after discharge from an inpatient setting.

Disproportionate share hospital (DSH) – A hospital that provides care to a high number of patients who cannot afford to pay and/or do not have insurance.

Diversion – The routing of patients to other hospitals because an emergency room is at maximum capacity.

Effective Date – The date your insurance is to begin. You are not covered until the policy's effective date.

Enrollment Period – Period during which individuals may enroll for an insurance policy, Medicare, or Health Insuring Corporation/Health Maintenance Organization (HMO) benefits.

Exclusion – A procedure or condition that an insurance policy does not cover.

Experience rating – A system where an insurance company evaluates the risk of an individual or group by looking at the applicant's health history.

Experimental – Medical treatment that is not generally accepted in the medical profession. Insurance policies often do not cover these procedures. Companies often disagree with doctors on whether a specific procedure or treatment is experimental.

Explanation of Benefits (EOB) – A statement from an insurance company showing which payments have been made on a claim.

Federal poverty guidelines (FPL) – The official annual income level for poverty as defined by the federal government. Under the 2008 guidelines, the federal poverty level for a family of four is …..GET INFORMATION.

Federally Eligible Individual (FEI) – A person who meets federal standards for continuing or obtaining health care coverage under HIPAA.

Fee for Service – Traditional insurance that does not place restrictions on which doctors you can use. The insurer pays for the expense you incur.

Fee schedule – A comprehensive listing of fees used by either a health care plan or the government to reimburse providers on a fee-for-service basis.

Free Look – The period during which you may reconsider the purchase of an insurance policy, cancel and get a full refund. Individual health policies have a free look of at least 10 days; Medicare supplement and long-term care polices have 30-day free look periods.

Gatekeeper – A primary care physician responsible for overseeing and coordinating all aspects of a patient's medical care and pre-authorizing specialty care.

General practitioner – A physician whose practice is based on a broad understanding of all illnesses and who does not restrict his/her practice to any particular field of medicine.

Generic Drug – A "twin" to a "brand name drug" once the brand name company's patent has run out and other drug companies are allowed to sell a duplicate of the original. Generic drugs are cheaper, and most prescription and health plans reward clients for choosing generics.

Grace Period – A specified period after a premium payment is due on an insurance policy, during which the policyholder may still make a payment. The policy remains in effect during the grace period.

Group Insurance – A contract between an insurer and an employer or association.

Group model HMO – An HMO that contracts with a multi-specialty medical group to provide care for HMO members. Members are required to receive medical care from a physician within the group unless a referral is made outside the network.

Guaranty Issue – An insurance policy that is issued to anyone, regardless of health.

Guaranteed Renewable – As agreement by an insurance company to insure a person for as long as premiums are paid.

Health Advocacy Services – Professional services designed to provide direct guidance to an individual and educate them on how to better use the healthcare system and the benefits available to them. For example, the advocate may help guide an individual through the healthcare maze, or educate an individual on alternative resources to help pay for prescriptions.

Health Care Decision Counseling – Services, sometimes provided by insurance companies or employers, that help individuals weigh the benefits, risks, and costs of medical tests and treatments. Unlike case management, health care decision counseling is non-judgmental. The goal of health care decision counseling is to help individuals make more informed choices about their health and medical care needs, and to help them make decisions that are right for the individual's unique set of circumstances.

Health Coaching – Healthcare professional (i.e., nurse, dietician, exercise physiologist, health coach) provides guidance to an individual regarding their personal health situation. For example, a dietician may create a weekly meal schedule for someone needing a healthier diet.

Health Insurance Portability and Accountability Act (HIPAA) – Federal law that guarantees health care plan eligibility for people who change jobs, if the new employer offers group insurance. Effective July 1, 1997.

Health Insuring Corporation (HIC) – A new term for managed care insurers in Ohio. HIC's include all Ohio HMO's and other companies that offer prepaid managed care. HIC's are regulated by the Department of Insurance.

Health Maintenance Organizations (HMOs) – Health Maintenance Organizations represent "pre-paid" or "capitated" insurance plans in which individuals or their employers pay a fixed monthly fee for services, instead of a separate charge for each visit or service. The monthly fees remain the same, regardless of types or levels of services provided. Services are provided by physicians who are employed by, or under contract with, the HMO. HMOs vary in design. Depending on the type of the HMO, services may be provided in a central facility, or in a physician's own office.

Health Risk Assessment (HRA) – Generally a short questionnaire, either on-line or paper, completed by an individual asking questions about their health status, personal and family history, health-related behaviors that predict the likelihood of future disease, and readiness to change. The participant receives a summary report highlighting their health risks and programs available to them to help manage their risks.

Health Savings Account (HSA) – A new health coverage option that is similar to a Medical Savings Account (MSA). A major advantage to an HSA is that savings may be carried over from one calendar year to another.

Home health agency – An organization that provides medical, therapeutic or other health services in patient's homes.

Hospice – A facility or program that is licensed, certified or otherwise authorized by law to provide supportive care to the terminally ill.

Hospital affiliation – A contractual relationship between a health insurance plan and one or more hospitals whereby the hospital provides the inpatient benefits offered by the plan.

Hospital Care Assurance Program (HCAP) – Ohio's Medicaid disproportionate share hospital program in which hospitals are assessed to attract federal matching funds to help hospitals provide care to the indigent.

Hospital Indemnity Policy – Pays a fixed dollar amount for each day you are in the hospital, regardless of actual hospital bills.

Indemnity Health Plan – Indemnity health insurance plans are also called "fee-for-service." These are the types of plans that primarily existed before the rise of HMOs, IPAs (Independent Practice Associations), and PPOs. With indemnity plans, the individual pays a pre-determined percentage of the cost of health care services, and the insurance company (or self-insured employer) pays the other percentage. For example, an individual might pay 20% for services and the insurance company pays 80%. The fees for services or defined by the providers and vary from physician to physician. Indemnity health plans offer individuals the freedom to choose their health care professionals.

Independent Practice Associations (IPAs) – IPAs are similar to HMOs, except that individuals receive care in a physician's own office, rather than in an HMO facility.

Indigent medical care – Care given by health care providers to patients who are unable to pay for it.

Individual Health Insurance – A contract between an insurance company and an insured person.

In-Network – Providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.

Inpatient – A person who has been admitted to a hospital or other health care facility to receive diagnosis, treatment or other health services.

Insured – An individual or organization protected by an insurance policy.

Intermediary organization (IO) – Under Ohio law, a health delivery network or other entity that contracts with health insuring corporations (HIC) or self-insured employers, or both, to provide health care services. The intermediary organization also contracts with other entities for the provision of health care services to fulfill the terms of its HIC and self-insured employer arrangements.

Intermediate care facility – A facility providing a level of medical care that is less than the degree of care and treatment that a hospital or skilled nursing facility is designed to provide but greater than the level of room and board.

Lifestyle Behavioral Change Programs – Programs designed to help individuals with a particular health condition (i.e. weight management, smoking cessation). The goal is to help participants take action to change lifestyle behaviors. Programs are often subsidized to encourage participation.

Lifetime Maximum – The total amount a policy during and insured's lifetime.

Limitations – A limit on the amount of benefits paid out for a particular covered expense, as disclosed on the Certificate of Insurance.

Limited-service, physician-owned hospital – A health care provider designed to provide principally one or two specialties of medical care (such as orthopedic or cardiac care), whose practicing physicians are also owners or investors. Also called a niche or specialty hospital.

Living will – A legal document generated by an individual to guide providers on the desired medical care in cases when the individual is unable to articulate his or her own wishes.

Long term acute care hospital (LTCH or LTACH) – A hospital that specializes in treating patients with serious and often complex medical conditions requiring a longer length of stay than customarily provided by a traditional acute care hospital. LYCHs provide care for such conditions as respiratory failure, non-healing wounds, and other medically-complex diseases.

Long-term Care (LTC) – The medical and social care given to one who has a severe chronic impairment over a long period of time.

Long-term Care Policy – Insurance policies that cover specified services for a specified period of time. Long-term care policies (and their prices) vary significantly. Covered services often include nursing care, home health care services, and custodial care.

Long-term Disability Insurance – Pays an insured a percentage of their monthly earnings if they become disabled.

LOS – Length of Stay. It is a term used by insurance companies, case managers and/or employers to describe the amount of time an individual stays in a hospital or in-patient facility.

Loss – The basis for a claim under an insurance policy. In health insurance, loss can refer to medical expenses (or, in a disability policy, loss of income) resulting from illness or injury.

Loss Ratio – The dollar amount an insurer pays in claims compared to the amount it collects from all customers in premiums. Loss ratio is usually shown as a percentage of claims for every dollar collected.

Major diagnostic category (MDC) – A hospital classification system that groups patients by diseases and disorders of each major body system. Diagnostic related groups (DRG) are classified underneath each MDC.

Malpractice – The improper treatment of a patient, as by a physician or nurse, resulting in injury.

Managed Care – A medical delivery system that attempts to manage the quality and cost of medical services that individuals receive. Most managed care systems offer HMOs and PPOs that individuals are encouraged to use for their health care services. Some managed care plans attempt to improve health quality, by emphasizing prevention of disease.

Maximum Dollar Limit – The maximum amount of money that an insurance company (or self-insured company) will pay for claims within a specific time period. Maximum dollar limits vary greatly. They may be based on or specified in terms of types of illnesses or types of services. Sometimes they are specified in terms of lifetime, sometimes for a year.

Medical Savings Account (MSA) – A special kind of account that is eligible for a tax credit when combines with catastrophic care insurance that has high deductibles.

Medically Necessary – Treatments or services an insurance policy will pay for as defined in the contract. Check you policy for specific language defining medically necessary.

Medical error – The failure of a planned action to be completed as intended (error of execution) or the use of a wrong plan to achieve an aim (error of planning).

Medicare Dependent – A Medicare reimbursement category for a hospital that is located in a rural area, has no more than 100 beds, and has had at least 60% of its inpatient days or discharges attributed to Medicare beneficiaries during a cost report year beginning in federal fiscal year 1987.

Medicare Part A – The part of the Medicare program covering inpatient hospital services and services furnished by other health care providers such as nursing homes, home health agencies and hospices. Part A coverage is automatically provided for individuals entitled to Medicare.

Medicare Part B – The part of the Medicare program that covers outpatient, physician and medical supplier services. Part B coverage is optional and must be paid for separately through monthly premium payments.

Medicare Part D – The part of the Medicare program that covers prescription drug coverage. Beginning in 2006, beneficiaries have access to partial prescription drug coverage paid mainly through state payments, premiums and general revenue. Some assistance for low-income beneficiaries is available for premiums and co-pays.

Medigap Insurance Policies – Medigap insurance is offered by private insurance companies, not the government. It is not the same as Medicare or Medicaid. These policies are designed to pay for some of the costs that Medicare does not cover.

Morbidity – Incidents of illness and accidents in a defined group of individuals.

Mortality – Incidents of death in a defined group of individuals.

Most-favored-nation (MFN) clause – A provision requiring the contracting physician, hospital or group to provide an insurer with the lowest price it charges any other insurer.

Multiple Employer Welfare Arrangement (MEWA)//Multiple Employer Trust (MET) – An organization of employers who "jointly self-insure" and pool funds to provide health care benefits for their employees. Ohio law requires a MEWA to either buy an insurance policy that covers its member' employees, or meet the financial standards for an insurance company.

Network – A group of doctors, hospitals and other health care provider contracted to provide services to insurance company customers for less then their usual fees. Provider networks can cover a large geographic market or a wide range of health care services. Insured individuals typically pay less for using a network provider.

Nosocomial infections – An infection acquired by an individual while receiving care or services in a health care organization.

Open-ended HMOs – HMOs which allow enrolled individuals to use out-of-plan providers and still receive partial or full coverage and payment for the professional's services under a traditional indemnity plan.

Open Enrollment – A period of time when new subscribers may enroll in a health insurance plan, regardless of their health.

Osteopathic – A school of medicine that uses manipulative measures in treating patients in addition to the diagnostic and therapeutic measures of medicine. The other shools is allopathic.

Outcome measures – Assessments to gauge the results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.

Outlier – A patient case that falls outside of the established norm for diagnosis related group (DRG).

Out-of-area benefits – The coverage allowed to HMO member for emergency and other situations outside of the prescribed geographic area of the HMO.

Out-of-Plan (Out-of-Network) – This phrase usually refers to physicians, hospitals or other health care providers who are considered nonparticipants in an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual's insurance company.

Out-of-Pocket Maximum – A predetermined limited amount of money that an individual must pay out of their own savings, before an insurance company (or self-insured employer) will pay 100% for an individual's health care expenses.

Out-of-State Group Policies – A group policy that is sold outside of Ohio. Example: you may live in Ohio and be covered by a policy your group purchased in Indiana. That policy may be regulated by Indiana law rather than Ohio Law.

Outpatient – A patient who receives care at a hospital or other health facility without being admitted to the facility. Outpatient care also refers to care given in other locations such as outpatient clinics.

Palliative care – Care for not only physical symptoms, but also for emotional, social, spiritual, psychological and cultural symptoms to achieve the best possible quality of life. Palliative care is usually provided at the end of life or to help deal with chronic conditions.

Participating provider – A health care provider who has a contractual arrangement with a health care service contractor, HMO, PPO, IPA, or other managed care organization.

Payer – a public or private organization that pays for or underwrites coverage for health care expenses.

Per diem – A method of payment in which a provider receives a fixed payment for each day of service provided to a patient.

Per member per month (PMPM) – The amount of money paid or received on a monthly basis for each individual enrolled in a managed care plan, often referred to as capitation.

Physician assistant (PA) – A health care professional licensed to practice medicine with physician supervision; governed by the Ohio State Medical Board (OSMB). PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventative health care, and assist in surgery.

Plan Administration – Supervising the details and routine activities of installing and running a health plan, such as answering questions, enrolling individuals, billing and collecting premiums and similar duties.

Point-of-service (POS) – An insurance plan where members need not choose how to receive services until the time they need them, also known as an open-ended HMO.

Pre-Admission Certification – Also called pre-certification review, or pre-admission review. Approval by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or in-patient facility, granted prior to the admittance. Pre-admission certification often must be obtained by the individual. Sometimes, however, physicians will contact the appropriate individual. The goal of pre-admission certification is to ensure that individuals are not exposed to inappropriate health care services (services that are medically unnecessary).

Pre-admission Testing – Medical tests that are completed for an individual prior to being admitted to a hospital or inpatient health care facility.

Pre-existing Condition – Health conditions or problems that existed before health insurance was purchased. Check you policy for specific language defining pre-existing conditions.

Pre-certification – A requirement that you obtain the insurance company's approval before a medical service is provided. If you fail to follow the pre-certification procedures the company may reduce or deny claim payment. Please note: getting pre-certification does not guarantee claim payment.

Preferred Provider Organizations (PPOs) – You or your employer receive discounted rates if you use doctors from a pre-selected group. If you use a physician outside the PPO plan, you must pay more for the medical care.

Prenatal care – Services to pregnant women designed to ensure that both expectant mother and the newborn are in the best health. A lack of prenatal care early in the pregnancy is associated with low birth weight and infant mortality.

Preventative care – Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination and immunizations.

Primary Care Provider (PCP) – A health care professional (usually a physician) who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a "quarterback" for an individuals medical care, referring the individual to more specialized physicians for specialist care.

Primary Payer – Health insurance policy that pays first when a person is covered by more than one insurance plan.

Provider – A person or organization that provides medical services, such as a doctor, hospital, x-ray company, home health agency, pharmacy, etc.

Quality assurance – A formal set of activities to review and improve the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.

Quality improvement – A continuous effort to provide services at the highest level of quality at the lowest level of cost.

Rate-setting – The determination by a government body of rates a health care provider may charge private pay patients.

Reasonable and Customary Fees – The average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the amount of money they will approve for a specific test or procedure. If the

fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference. Sometimes, however, if an individual questions his or her physician about the fee, the provider will reduce the charge to the amount that the insurance company has defined as reasonable and customary.

Reinsurance – A type of insurance purchased by primary insurers from secondary insurers. A commercial or captive insurance company purchases reinsurance to protect against part of all losses the primary insurer might assume in honoring claims of its policyholders. Typically, primary insurer pays a claim up to a specified amount, and then a reinsurer pays the remainder of the clam.

Return on Investment (ROI) – A performance measure used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments. The ROI is calculated by determining the benefit (return) of an investment divided by the cost of the investment. The result is expressed as a percentage or a ratio.

Rider – A legal document that modifies an insurance policy. Riders may either extend or decrease benefits, or add or exclude specific conditions.

Risk – The chance of loss, the degree of probability of loss or the amount of possible loss to the insuring company. For an individual, risk represents such probabilities as the likelihood of surgical complications, medications' side effects, exposure to infection, or the chance of suffering a medical problem because of a lifestyle or other choice. For example, an individual increases his or her risk of getting cancer if he or she chooses to smoke cigarettes.

Safety net providers – Provider who have a mission or mandate to deliver large amounts of care to uninsured or other vulnerable patients (e.g., public hospitals, teaching hospitals, community health centers, or clinics).

Second Opinion – it is a medical opinion provided by a second physician or medical expert, when one physician provides a diagnosis or recommends surgery to an individual. Individuals are encouraged to obtain second opinions whenever a physician recommends surgery or presents an individual with a serious medical diagnosis.

Second Surgical Opinion – These are now standard benefits in many health insurance plans. It is an opinion provided by a second physician, when one physician recommends surgery to an individual.

Secondary Payer – Applies only when you have more than one health insurance plan. The secondary payer is the plan whose payments cannot be made until another plan (the primary payer) has processed the claim.

Self-insured Plan – An organization (usually an employer) that pays health care costs out of the organizations own pocket.

Sentinel event – An unexpected occurrence involving death or serious physical or psychological injury, or the risk, thereof.

Short-term Disability – An injury or illness that keeps a person from working for a short time. The definition of short-term disability (and the time period over which coverage extends) differs among insurance companies and employers. Short-term disability insurance coverage is designed to protect an individual's full or partial wages during a time of injury or illness (that is not work-related) that would prohibit the individual from working.

Short-term Medical – Temporary coverage for an individual for a short period of time, usually from 30 days to six months.

Specific Disease Policy – A health insurance policy that covers the expenses incurred only for a specific disease named in the policy. The most common type is cancer insurance. Also known as Dread Disease policy.

Staff model HMO – An HMO that delivers health services through a group in which physicians are salaried employees who treat HMO members exclusively.

State Mandated Benefits – When a state passes laws requiring that health insurance plans include specific benefits.

Stop-Loss – The dollar amount of claims filed for eligible expenses at which point you've paid 100% of your out-of-pocket and the insurance begins to pay at 100%. Stop-loss is reached when an insured individual has paid the deductible and reached the out-of-pocket maximum amount of co-insurance.

Subacute care – Care given to patients who require less than a 30-day length of stay in a hospital and have a more stable condition than those receiving acute care.

Supplemental medical insurance – Private health insurance, also called medigap insurance, designed to supplement Medicare benefits by covering certain health care costs that are not paid for by the Medicare program.

Tail insurance – A form of liability insurance that covers past incidents that were not previously reported as claims. An insured who changed insurance companies, or a physician who retires, may need to purchase tail insurance to cover incidents that occurred, but were not reported as claims before the change in insurance companies or retirement.

Teaching hospital – A hospital that has an accredited medical residency training program and is typically affiliated with a medical school.

Tertiary care – Highly specialized care given to patients who are in danger of disability or death.

Third-party Administrator – A person or organization that manages the payment, processing and settlement of life, health, dental, disability and self-insured insurance claims for another person or organization.

Triage – the process by which patients are sorted or classified according to the type and urgency of their conditions.

Triple-Option – Insurance plans that offer three options from which an individual may choose. Usually, the three options are: traditional indemnity, an HMO and a PPO.

Uncompensated care – All health care services for which a provider is not compensated, including bad debt, charity care, and other services that go unpaid.

Underinsured – People with some type of health insurance but not enough cover all of their health care needs.

Underwriting – The process by which an insurer establishes and assumes risks. An insurance company is underwriting when it agrees to insure you because you are healthy or rejects your application because you have a history of health problems.

Uninsured – People who lack health insurance of any kind.

Usual, Customary and Reasonable (UCR) – The dollar amount a company has determined to be appropriate for a particular medical service. Each company develops its own UCR. It is often less than doctors actually charge.

Utilization – The patterns of use of a service or type of service within a specified time, usually expressed in a rate per unit of population-at-risk for a given period (e.g., the number of hospital admissions per year per 1,000 persons in a geographic area.)

Value Based Plan Design – The approach focuses on the value of clinical services (i.e. benefits and cost), not exclusively on costs.

Wage index – A factor used to adjust the base Medicare reimbursement rates for an area to account for geographic differences in wages paid to health care workers. Some argue that such difference no longer exist and that the wage index formula should be changed or eliminated.

Waiting Period – The time that must pass after becoming insured before the policy will begin to pay benefits for a pre-existing condition or specified illness. It may also refer to the time you must wait before you can get group health insurance from a new employer.

Waiver – An amendment to a health insurance policy that excludes coverage for a specific condition.

Well-baby care – Services provided in the first year of newborn's life to identify, treat and prevent health care problems.