



## *Health Insurance Glossary*

### **A**

**Accountable Care Organization (ACO):** An Accountable Care Organization is a group of Doctors, hospitals and other healthcare providers who work together to provide you with coordinated care.

**Actuarial Justification:** The demonstration by an insurance company that the premiums collected are reasonable, given the benefits provided under the plan, or that the distribution of premiums among policyholders are proportional to the distribution of their expected costs, subject to limitations of state and federal law. The ACA requires health insurance companies to publicly disclose the actuarial justifications behind unreasonable premium increases.

**Actuarial Value:** The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits after paying your premium. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

**Advanced Premium Tax Credits (APTC):** A tax credit that can reduce what you pay for insurance. When you apply for coverage in the Health Insurance Marketplace, you estimate your expected income. If your estimate falls in the range to save, you can use an advance payment of the premium tax credit to lower your monthly insurance bill. If at the end of the year you've taken more premium tax credit in advance than you're due based on your final income, you'll have to pay back the excess when you file your federal tax return. If you've taken less than you qualify for, you'll get the difference back. If you're concerned about having to pay back any excess tax credits, you may choose to not take them in advance, and take them instead when you file your federal tax return.

**Adverse Benefit Determination:** A plan's decision to deny a claim, in whole or in part, based on medical judgment or rescission.

**Affordable Care Act (ACA):** Also known as the Patient Protection and Affordable Care Act - is the federal healthcare reform legislation signed by President Obama in March 2010. The ACA is also known as "Obamacare."

**Agent:** An agent is a person or business who can help you apply and enroll you in health insurance. An agent may also be called a producer. An agent can make specific recommendations about which plan you should enroll in. Agents typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer's plans. Some agents may only be able to sell plans from specific health insurers.

**Allowable Charge:** The maximum dollar amount that your health insurance company will pay a health care provider for a benefit (i.e. healthcare service) covered by your health insurance plan.

**Annual Limit:** The maximum dollar amount that a health insurance company will pay for a particular benefit over the course of a plan year. Health insurance companies are prohibited from placing annual limits on essential health benefits.

**Appeal:** To ask that a health plan reconsider its decision to deny payment for a treatment or service.

**Association Health Plans (AHPs):** Under the Department of Labor's (DOL) rule, are group health plans that employer groups and associations offer to provide health coverage for employees. To be recognized as an association, a form M-1 must be approved by the DOL.

## B

**Balance Billing:** When you receive services from a healthcare provider that does not participate in your health insurance plan's network, the provider may bill you for the difference between the dollar amount charged to your health insurance company and the dollar amount your health insurance company actually paid (the allowable charge) for the services.

**Benefit Year:** A year of benefits coverage under a health insurance plan. The benefit year for individual plans bought inside or outside the Marketplace begins January 1 of each year and ends December 31 of the same year.

**Brand Name (Drugs):** A drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand name drugs may be available by prescription or over the counter.

## C

**Catastrophic Health Plan:** A health plan that meets all the requirements applicable to other Qualified Health Plans (QHPs) but that doesn't cover any benefits other than 3 primary care visits per year before the plan's deductible is met. The premium amount you pay each month for a catastrophic health plan is generally lower than for other QHPs, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher. To qualify for a catastrophic plan, you must be under 30 years old OR get a "hardship exemption" from the Marketplace (based on a determination by the Marketplace that you're unable to afford health coverage).

**Center for Consumer Information and Insurance Oversight (CCIIO):** An organization that oversees the implementation of the parts of the Affordable Care Act related to private insurance.

**Centers for Disease Control and Prevention (CDC):** The nation's health protection agency.

**Centers for Medicare and Medicaid Services (CMS):** A federal agency that administers Medicare, and, in partnership with the state, Medical Assistance and the Children's Health Insurance Program.

**Certified Application Counselor:** An individual (affiliated with a designated organization) who is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers.

**Children's Health Insurance Program (CHIP):** The Children's Health Insurance Program provides coverage to eligible children and teens up to age 19. Like Medical Assistance, it is jointly funded and administered by the states and the federal government.

**Claim:** A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.

**Co-Op Plan:** A health insurance plan sold by member-owned and operated nonprofit organizations through exchanges. The ACA provides grants and loans to help Co-Op plans enter the marketplace. There are no Co-Op plans operating in West Virginia.

**Co-insurance:** The percentage of a health insurance company's allowable charge the patient is financially responsible for under the health insurance plan's terms. For example: If the allowable charge for a service is \$200 and your health insurance plan has a 10% co-insurance, the health insurance company will pay \$180 and you will be responsible to pay \$20.

**Community Health Center (CHC):** A community-based organization that serves populations with limited access to healthcare.

**Community Rating:** A way of pricing insurance in which every enrollee pays the same premium, regardless of health status, age or other factors. The ACA requires modified community rating, where an enrollee's premium may be adjusted based family size, geography, age and tobacco use.

**Consolidated Omnibus Budget Reconciliation Act (COBRA):** Passed in Congress in 1986, COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporarily continue their health coverage at group rates. The law generally covers health plans maintained by private employers with 20 or more employees, employee organizations or state or local governments. (For smaller employers, see "Mini-COBRA".)

**Conversion:** The ability to switch coverage. For example, the ability to switch from job-based coverage to individual coverage when the group continuation coverage through COBRA, PA Mini-COBRA or group coverage ends.

**Coordination of Benefits (COB):** A way insurers use to figure out which company pays first and for which charges when 2 or more health insurance plans are responsible for paying the same medical claim.

**Co-payment:** The flat-dollar amount a patient must pay when visiting a doctor or other healthcare provider. The co-payment is a pre-determined fee under the health insurance plan's terms and does not change based on the allowable charge.

**Cost-Sharing:** The portion of charges for a healthcare service that a patient is responsible to pay. Common forms of cost-sharing include deductibles, co-insurance and co-payments. The total dollar amount of cost-sharing allowed over the course of a plan year is called the out-of-pocket maximum.

**Cost-Sharing Reduction:** A discount received through the Marketplace that lowers the amount you must pay out-of-pocket for deductibles, co-insurance, and co-payments. You also have a lower out-of-pocket maximum. You can get these savings if your income is below a certain level, and only if you choose a health plan from the Silver plan category through the Marketplace.

**Current Procedural Terminology Codes (CPT Codes):** CPT codes are numbers assigned to a medical, surgical or diagnostic service a health practitioner provides. These codes are used by insurers to determine how much to pay a provider for medical services.

## D

**Deductible:** A dollar amount that a patient must pay for healthcare services each plan year before the insurance company will begin paying claims. Some services, like preventive services, are not subject to the deductible and will be covered whenever you need them.

**Department of Health and Human Services (HHS):** The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those least able to help themselves.

**Dependent Coverage:** Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

## E

**Employee Benefits Security Administration (EBSA):** An organization within the federal Department of Labor that assures the security of the retirement, health and other workplace related benefits of America's workers and their families.

**Employee Retirement Income Security Act of 1974 (ERISA):** ERISA is a comprehensive and complex statute that federalizes the law of employee benefits. ERISA applies to most kinds of employee benefit plans, including plans covering healthcare benefits that employers fund directly, rather than through insurance, which are called employee welfare benefit plans.

**Essential Health Benefits (EHBs):** Ten categories of benefits, including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services. Health insurance plans sold after 2014 are required to provide the essential health benefits and will have restrictions on the amount of cost-sharing that patients must pay for these services.

**Exchange:** The online store, also called the Marketplace, where individuals and small employers may buy health insurance plans sold by insurance companies. You can get to the exchange by going to [www.healthcare.gov](http://www.healthcare.gov).

**Exemption:** Under the individual mandate, most people who do not have health insurance have to pay a penalty each year. However, some people are eligible for exemptions, which allow them to not pay a penalty even if they do not have health insurance. Exemptions are granted based on certain hardships, membership in some groups, and other circumstances.

**Explanation of Benefits (EOB):** A document sent to you by your health insurance company that gives you information about how an insurance claim from a healthcare provider for services provided to you was processed and what portion was paid by the health insurance company on your behalf. The EOB will also explain what dollar amount a healthcare provider may charge you if you are responsible for any cost-sharing under the health insurance plan.

**External Review:** An independent review of a health plan's Adverse Benefit Determination.

## F

**Federal Poverty Level (FPL):** A federal estimate of the point below which a household has income insufficient to meet minimal basic needs. Tax credits received through the Marketplace are based on how your income compares to the FPL. Individuals and families with incomes up to four times (400%) of the FPL are eligible for subsidies through the Marketplace.

**Federally Qualified Health Center (FQHC):** A community-based organization that provides comprehensive primary care and preventive care to people regardless of their ability to pay or health insurance status.

**Fee-for-Service (FFS):** A type of health insurance plan in which the policyholder or beneficiary may see any provider, pay directly for a service, and submit a claim to the insurance company, and, if the service is covered in the policy, receive reimbursement for some or all of their payment.

**First Dollar Coverage:** Coverage for expenses beginning with the first dollar charged for healthcare - without a deductible having to be paid first.

**Flexible Spending Account (FSA):** An account set up through your employer to pay for eligible medical expenses with tax-free dollars. There is usually a maximum amount you can contribute, and any amount not used will be lost, so plan carefully.

**Formulary:** The list of prescription drugs covered in full or in part by a health plan.

**Fully Insured:** A plan is fully insured when all covered benefits will be paid under a contract of insurance that transfers the risk to an insurance company.

## G

**Generic Drugs:** A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

**Grandfathered Plan:** A health plan that an individual was enrolled in prior to March 23, 2010. Grandfathered plans are exempted from most changes required by the ACA if no significant changes have been made to the benefits covered by the plan. New employees and family members may be added to existing group plans that are grandfathered, but grandfathered plans are no longer sold to new customers.

**Group Health Plan:** An employee benefit plan established or maintained by an employer or by an employee organization (such as a union), that provides medical care for participants or their dependents. A group health plan may be fully or partially insured or may be fully or partially paid for directly by the employer or employee organization.

**Guaranteed Issue:** A requirement that health insurance companies sell a health insurance plan to any person who requests coverage. All health insurance is now sold on a guaranteed-issue basis.

**Guaranteed Renewability:** A requirement that health insurance companies renew coverage under a health plan except for failure to pay premiums or fraud. Federal law requires that all health insurance be guaranteed renewable.

## H

**Health Maintenance Organization (HMO):** A type of managed care organization (health plan) that provides healthcare coverage through a network of hospitals, doctors and other healthcare providers. Typically, the HMO only pays for care that is provided by an in-network provider.

**Health Savings Account (HSA):** A type of medical savings account that allows an individual to save money on a tax-preferred basis to be used for future qualified medical and retiree health expenses. In order to be eligible to use a HSA individuals need to be covered by a qualified high-deductible health plan (HDHP).

**High-Deductible Health Plan (HDHP):** A type of health insurance plan that typically requires greater out-of-pocket spending than traditional health insurance plans, although premiums may be lower. HDHPs are often paired with an HSA or other medical savings account that allows money to be deposited into a separate account on a tax-preferred basis to help pay for the higher out-of-pocket spending.

**Home and Community-Based Services:** A program that provides services and support to people with intellectual and developmental disabilities who are living with their family, in their own home or in other community settings, such as small group homes.

## I

**In-Network Provider:** A healthcare provider (such as a hospital or doctor) that is contracted to be part of a health plan's network. You will pay less out-of-pocket if you see an in-network provider than if you see an out-of-network provider.

**Independent Review Organization (IRO):** An independent third-party organization contracted to conduct an external review of health appeals.

**Individual Mandate:** Under the ACA, the individual mandate is a requirement that everyone have health insurance coverage. The ACA requires that everyone who can purchase health insurance for less than eight percent of their household income do so or pay a tax penalty.

**Individual Market:** The market for health insurance coverage offered to individuals not in a group health plan.

**Internal Appeal or Review:** A review of a health plan's determination that a requested or provided healthcare service or treatment is not or was not medically necessary. All plans are required to conduct an internal review upon the request of the patient or the patient's representative.

## L

**Large Group Health Plan:** In general, a group health plan that covers employees of an employer that has 51 or more employees.

**Limited Benefit Plan:** A type of health plan that provides coverage for only certain specified healthcare services or treatments or provides coverage for healthcare services or treatments for a certain dollar amount during a specified period. Limited benefit plans are not considered minimum essential coverage, so individuals with only these plans may be subject to the individual mandate penalty.

**Long-Term Care Insurance:** Insurance used to pay for services that assist an individual who is no longer able to adequately or safely perform activities of daily living for an extended period of time due to age or disability.

## M

**Mandated Benefit:** A requirement in state or federal law that all health insurance plans provide coverage for a specific healthcare service.

**Marketplace:** The online store, also called the exchange, where individuals may buy health insurance plans sold by insurance companies. West Virginia uses the federal Marketplace, at [www.healthcare.gov](http://www.healthcare.gov).

**Medicaid:** Medicaid is a joint state and federal program that provides healthcare coverage to eligible individuals.

**Medical Loss Ratio (MLR):** The percentage of health insurance premiums that are spent by an insurance company on healthcare services. Large group plans are required to spend 85 percent of premiums on clinical services and other activities devoted to the quality of care for enrollees. Small group and individual market plans must devote 80 percent of premiums to these purposes.

**Medical Underwriting:** The process an insurance plan uses to determine your health status when you are applying for insurance to decide whether or not to offer you coverage, how much to charge you for coverage and if there will be exclusions or limits. Under the ACA, health insurers may no longer deny you coverage and can only vary how much you pay by your age, where you live, and how many people will be covered by your plan. But, other types of insurance like long-term care may still use medical underwriting practices.

**Medically Necessary or Medical Necessity:** Generally speaking, services or supplies your health care provider determines are needed for prevention, diagnosis or treatment of a patient's illness or injury or other medical condition that meet generally accepted medical standards and are clinically appropriate for the patient. Your health plan may have a more specific definition.

**Medicare:** A federal program that provides healthcare coverage for all eligible individuals age 65 or older, or individuals under age 65 with a disability, regardless of income or assets. Eligible individuals can receive coverage for hospital services (Medicare Part A), medical services (Medicare Part B) and prescription drugs (Medicare Part D). Together, Medicare Parts A and B are known as original Medicare. Benefits can also be provided through a Medicare Advantage Plan (Medicare Part C).

**Medicare Advantage:** Also known as Medicare Part C, this option provides Medicare beneficiaries with most or all their Medicare benefits through a managed care plan from a health insurance company. Health insurance companies contract with the federal government and are required to offer at least the same benefits as original Medicare but may follow different rules and offer additional benefits.

**Medicare Part D:** A program that helps pay for prescription drugs for people with Medicare. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

**Medigap (Medicare Supplement) plan:** A private insurance plan that can be purchased by someone who has Medicare to "fill in the gaps" and pay for certain out-of-pocket expenses (like deductibles and coinsurance) not covered by original Medicare (Parts A and B).

**Minimum Essential Coverage (MEC):** Any insurance that meets the Affordable Care Act requirement for having health coverage. If you have MEC you don't have to pay the tax penalty for being uninsured. Examples include: Health Insurance Marketplace plans; most individual plans bought outside the Marketplace; job-based insurance, including SHOP plans; Medicare; Medicaid; CHIP; TRICARE; and certain other coverage.

## N

**National Association of Insurance Commissioners (NAIC):** The U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and the five U.S. territories.

**National Committee for Quality Assurance (NCQA):** A private, not-for-profit organization dedicated to improving healthcare quality.

**National Institutes of Health (NIH):** The nation's medical resource agency.

**Navigator:** An individual or organization that is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

**Network:** The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services. Getting your health care services in-network means you will be subject to the lowest cost-sharing available under your plan.

**Network Adequacy:** For plans that use networks, the term for evaluating whether a plan has an adequate number and distribution of healthcare providers required to operate a health plan.

**Non-Grandfathered Plans:** Health plans that started after the ACA was signed into law or plans that existed before the law was signed that have made significant changes that reduced benefits and/or raised costs.

## O

**Obamacare:** An informal name sometimes used to refer to the health coverage plans available through the Health Insurance Marketplace. Obamacare is often another term for the Affordable Care Act.

**Open Enrollment Period (OEP):** A specified period during the year when individuals may enroll in a health insurance plan. In certain situations, such as a birth, death or divorce in a family, individuals may be allowed to enroll in a plan during a special enrollment period, which takes place outside of the open enrollment period.

**Out-of-Network Provider:** A healthcare provider (such as a hospital or doctor) that is not part of your health plan's network. Depending on the health insurance plan, you may be required to pay the total charge for the healthcare service or you may be required to pay a higher portion of the charge when you seek care from an out-of-network provider.

**Out-of-Pocket Costs:** Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, co-insurance, and co-payments for covered services plus all costs for services that aren't covered.

**Out-of-Pocket Maximum:** The total dollar amount of cost-sharing that a patient is responsible for paying under a health insurance plan. This limit does not apply to premiums, balance-billed charges from out-of-network healthcare providers or services that are not covered by the plan. The ACA defines limits on the total dollar amount of cost-sharing that a health insurance company may charge individuals and families, and these amounts may be adjusted annually.

## **P**

**Patient Protection and Affordable Care Act (PPACA):** See Affordable Care Act.

**Point of Service Plan (POS):** A health insurance plan that combines features of both an HMO and a PPO. A POS plan is similar to an HMO because typically requires you to identify a primary care physician and requires you to obtain a referral to see a specialist. A POS plan is also similar to a PPO plan, as a POS plan typically pays for out-of-network care, though a POS plan typically requires a primary care physician's referral to obtain out-of-network care.

**Pre-Existing Condition:** The period of time that an individual receives no benefits for an illness or medical condition that occurred before an insurance plan took effect. Pre-existing condition exclusions are no longer allowed in health insurance, but may be found in other types of policies, such as long-term care insurance or disability insurance.

**Preferred Provider Organization (PPO):** A type of managed care organization that provides coverage through a network of providers. Typically, a PPO will provide coverage for services that are provided by an out-of-network healthcare provider but will require you to pay higher costs for services provided out- of-network.

**Premium:** A recurring fee a health insurance company charges for your health insurance coverage, typically charged monthly. The amount of premium the health insurance company charges depends on your health insurance plan's type and level of coverage. The portion of premium you pay depends on whether part of the premium is paid by your employer, whether you qualify for tax credit and cost-sharing subsidies, and other factors.

**Premium Tax Credit:** A tax credit that can help you afford health coverage through the Marketplace. If you qualify for the premium tax credit based on your income, you can lower your monthly premium payment. If you take more advance payments of the tax credit than you qualify for based on your final yearly income, you must repay the difference when you file your federal income tax return. If the amount of advance payments you take is less than the tax credit you qualify for based on your final income, you'll get the difference as a refund when you file your taxes. If you're concerned about having to pay back any excess tax credits, you may choose to not take them in advance, and take them instead when you file your federal tax return.

**Preventive Benefits:** Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. Insurance companies are required to provide coverage for preventive benefits without deductibles, co-payments, co-insurance or any other cost-sharing.

**Primary Care Physician (PCP):** A primary doctor who gives general medical care and provides referrals to see a specialist.

**Prior Authorization:** Approval from a health plan that may be required before you get a service or fill a prescription for the service or prescription to be covered by your plan.

**Producer:** A health insurance producer is also known as either an agent. A producer is a person or business who can help you apply and enroll you in health insurance. They can make specific recommendations about which plan you should enroll in. Producers who are agents typically get payments or commissions from health insurers for enrolling a consumer into an issuer's plans. Some producers may only be able to sell plans from specific health insurers.

## Q

**Qualified Health Plan:** A health insurance plan that is sold on the Marketplace and meets all the standards required by the Marketplace.

## R

**Rate Review:** The review by insurance regulators of proposed premium increases. During the rate review process, regulators will examine proposed premiums to ensure that they are sufficient to pay all claims likely to be made in the coming year, that they are not unreasonably high in relation to the benefits being provided, and that they are not unfairly discriminatory to any individual or group of individuals.

**Referral:** A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor.

**Re-insurance:** Insurance that is purchased by insurance companies from other insurance companies to limit the total loss the company would experience in case of a disaster or unexpectedly high claims. The ACA created a temporary reinsurance program to stabilize the individual markets in each state for the first three years of coverage under the ACA, because many new customers have been getting coverage for the first time and it is a challenge for insurance companies to know how to price coverage without knowing how much health care the new customers likely will need, even though the companies are required to issue insurance to anyone willing to purchase it, regardless of their health status.

**Rescission:** Rescission is the retroactive cancellation of a health insurance policy. Rescission is prohibited except in cases of fraud or intentional misrepresentation of a relevant fact.

**Rider:** An amendment to an insurance policy.

**Risk Adjustment:** A process through which insurance plans that enroll a disproportionate number of sick individuals are reimbursed for this risk by other plans that enroll a disproportionate number of healthy individuals. Risk adjustment is required under the ACA for all non-grandfathered health insurance plans.

## S

**Second Lowest Cost Silver Plan (SLCSP):** The second lowest monthly premium for a Marketplace health plan in the Silver category in a given area is used by the IRS to calculate premium tax credits.

**Self-Funded or Self-Insured:** A plan is self-funded when the employer assumes the financial risk for providing healthcare benefits to the employees. Self-funded plans are regulated by the federal government, not a state.

**Short Term Limited Duration (STLD) Plan** – A type of health plan that provides coverage for only certain specified health care services or treatments or provides coverage for health care services or treatments for a certain amount during a specified period.

**Skilled Nursing Facility (SNF):** A facility that provides short- or long-term medical treatment, nursing, rehabilitation and other health services to patients.

**Small Group Market:** The market for health insurance coverage offered to small businesses that employ up to 50 individuals.

**Solvency:** The ability of a health insurance plan to meet all its financial obligations. State insurance regulators carefully monitor the solvency of all health insurance plans and require corrective action if a plan's financial situation becomes hazardous.

**Special Enrollment Period:** A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage. In the Marketplace, you qualify for a special enrollment period 60 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other health coverage. Job-based plans must provide a special enrollment period of 30 days.

**State Health Insurance Assistance Program (SHIP):** A free health benefits counseling service for Medicare beneficiaries and their families or caregivers.

**Summary of Benefits and Coverage (SBC):** An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. All plans are required to make SBCs available to consumers and they can be helpful tools if you are shopping for coverage.

## T

**Temporary Assistance for Needy Families (TANF):** A federal program to help move recipients into work and turn welfare into a program of temporary assistance.

**TRICARE:** A health care program for active-duty and retired uniformed services members and their families.

## U

**United States Department of Labor (DOL):** The Department of Labor (DOL) supports job seekers, wage earners, and retirees by improving their working conditions, helping them find work and protecting their retirement and healthcare benefits.

**United States Public Health Service (USPHS):** A federal organization that protects our nation's public health.

**Urgent Care Claim:** A claim you may make for expedited review of your denied claim. You may make this claim if a medical provider determines withholding care will endanger your life or cause you prolonged or severe pain.

**Usual, Customary and Reasonable Charge (UCR):** The cost associated with a healthcare service that is consistent with the going rate for identical or similar services within a particular geographic area. Reimbursement for out-of-network providers is often set at a percentage of the usual, customary and reasonable charge, which may differ from what the provider actually charges for a service.

## W

**Waiting Period:** A period of time that an individual must wait, either after becoming employed or submitting an application for a health insurance plan, before coverage becomes effective and claims may be paid. Premiums are not collected during this period.

**Wellness Program:** A program intended to improve and promote health that is usually offered through the work place, although insurance plans sometimes offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventive health screenings.

**West Virginia Offices of the Insurance Commissioner (WVOIC):** The government agency in West Virginia that regulates the business of insurance.