PTC *Cares*™
STRONGER TOGETHER

When it comes to understanding insurance terminology, we've got you covered

Insurance companies speak their own language and it's a language that can be difficult to understand. But with PTC *Cares*™, you don't need to worry. We're here to help you navigate the entire insurance process from beginning to end, and that includes helping you get a better understanding of the terms that insurance companies use.

This glossary will provide you with definitions for some of the more commonly used terms. And remember, if you have any questions, you can always call your PTC *Cares* Case Manager to get the answers.

The Affordable Care Act	Also known as Obamacare, was signed into law by President Barack Obama in 2010. It was designed to extend health coverage to millions of uninsured Americans. The Act expanded Medicaid eligibility, created a Health Insurance Marketplace, prevented insurance companies from denying coverage due to preexisting conditions, and required plans to cover a list of essential health benefits.
Annual Limit	The annual limit is the maximum benefit amount your insurance will cover in a year. These limits can be placed on services, prescriptions, or hospitalizations and can involve dollar amounts or number of visits for a service. You are responsible for additional payments after you reach your annual limit.
Appeal	When your health insurance company denies a benefit or refuses to make a payment, you may ask for an appeal in an effort to get that decision reversed.
Benefits	Healthcare provider visits, prescriptions, services, or other things covered under your insurance plan are called your benefits.
Benefit Year	A year of benefits coverage under an individual health insurance plan is called your benefit year. Each plan has a start and end date; yours may not line up with a calendar year.
Claim	A claim is the request for payment to cover a service that you or your healthcare provider submit to your insurance company.
COBRA	A COBRA (Consolidated Omnibus Budget Reconciliation Act) plan helps you keep the health insurance coverage you have through your employer if you lose that job. With COBRA, you pay the entire premium plus a small administrative fee.

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Coordination of Benefits	Coordination of Benefits (COB) is the process of determining which of two or more insurance policies will have the primary responsibility of processing/paying a claim and the extent to which the other policies will contribute.
Copay	A copay (or copayment) is the amount you pay for a covered service or prescription above what your insurance plan pays. The amount of your copay can change depending on whether you have met your deductible for the year or not.
Deductible	Your insurance company requires you to pay a certain amount of your covered medical bills first, before they will cover the cost. This is called your deductible. Family plans often have a deductible that applies to each person, plus a deductible that applies to your family as a whole. Once you've reached your annual deductible amount, your insurance company will likely pick up any remaining costs for the rest of that benefit year.
Denial Letter	Payers may issue denial letters after rejecting a claim for a variety of reasons, including lack of medical necessity and missing paperwork or lab results. It is important to save this document because it can clarify why a claim was denied and the appropriate next steps to initiate an appeal. In some cases, the healthcare provider will not receive a copy of this letter and will depend on you to provide it.
Dependent Coverage	Dependent coverage is coverage for the policyholder's dependent family members such as spouses, children, or partners.
Excluded Services	Excluded services are services your health insurance won't cover.
Explanation of Benefits	The Explanation of Benefits (EOB) is a written form from your insurance company that explains what they have paid, what they have not paid, and what you must pay on a specific claim. An EOB is not a bill; a bill for final payments owed will follow.
Formulary	The list of prescription drugs that are covered by your insurance policy's drug plan is called a formulary.
Grievance	A complaint that you have or file with your health insurer is called a grievance.
Letter of Medical Necessity	A letter written by a healthcare provider and submitted to your insurance company to help obtain coverage for costs they may not typically cover such as a wheelchair or a new medication. This letter is used to further describe the medical need for a patient to receive a treatment or service. A letter of medical necessity is very important in obtaining adequate reimbursement for treatment of rare diseases like Duchenne.
Medicaid	The program that lets low-income people, families and children, pregnant women, the elderly, and people with disabilities get free or low-cost federal health insurance.
Medicare	The federal health insurance program for people aged 65 or older and certain younger people with disabilities.
Out-of-Pocket Maximum	Out-of-Pocket Maximum (OOP) is the most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.
Payer	Payer is another word for insurance plan.

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Premium	Your insurance premium is the amount of money the insurance company charges you for your insurance policy; in other words, the cost of your insurance. If you get your insurance through your employer, it pays part of that premium.
Primary Care Provider	A primary care provider is the main healthcare provider, nurse practitioner, or other medical professional who provides general care and coordinates their patients' access to other services or specialists.
Primary Insurance	Some people are covered by more than 1 health insurance plan. In this case, their primary insurance will pay on a claim first before their secondary insurance (such as Medicaid) pays their amount of a covered claim.
Secondary Insurance	When people are covered by more than 1 health insurance plan (for example, the first through their employer and the second being Medicaid), their primary insurance will pay on a claim first before secondary insurance pays on a covered claim. **NOTE:** See Coordination of Benefits.
Specialist	A physician who specializes in one certain area of medicine or group of patients such as a neurologist (who treats the nervous system) or a pediatrician (who treats only children) is called a specialist.
Specialty Pharmacy	Specialty pharmacies are like traditional pharmacies but do not have a local presence. They offer additional services such as coordinating multiple aspects of patient care, assisting with insurance authorizations, and disease management. They are designed to deliver medications with special handling, storage, and distribution requirements.
Subsidized Coverage	Health coverage available at reduced or no cost for people with incomes below certain levels is considered subsidized coverage such as Medicaid or the Children's Health Insurance Program (CHIP).
TRICARE	A healthcare program for active-duty and retired uniformed service members and their families.

Have questions? We're always ready to help!

Call us at 1-844-4PTC-CARES (1-844-478-2227)

Monday - Friday / 8 AM - 6 PM ET

Courtney
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