Chapter 4: Description of Benefits

## ASO (Administrative Services Only)

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| ASO (Administrative Services Only) | An arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing; the employer bears the risk for claims. ♦ This is common in self-insured health care plans |
|  | Yes. CMS will continue its oversight efforts by re-reviewing a sample of BFCC-QIO completed claim reviews each month, monitoring provider education calls, and responding to individual provider inquiries and concerns. Providers may send questions to the CMS Open Door Forum Mailbox at [ODF@cms.hhs.gov](mailto:ODF@cms.hhs.gov). |
|  | The BFCC-QIOs were directed to use comprehensive outreach and communication approaches (i.e. website, newsletter, one-on-one training, and town hall type events) to continue to educate providers on when payment under Medicare Part A is appropriate under the Two-Midnight policy. |
| Coinsurance | A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.  Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges: the individual could also be responsible for any charges in excess of what the insurer determines to be “usual, customary and reasonable”. ♦ Coinsurance rates may differ if services are received from an approved provider (i.e., a provider with whom the insurer has a contract or an agreement specifying payment levels and other contract requirements) or if received by providers not on the approved list. ♦ In addition to overall coinsurance rates, rates may also differ for different types of services. |
| Copayment | A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement. ♦ There may be separate copayments for different services. ♦ Some plans require that a deductible first be met for some specific services before a copayment applies |
|  | Due to the unplanned nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be [life-threatening](https://en.wikipedia.org/wiki/Medical_emergency)and require immediate attention. In some countries, emergency departments have become important entry points for those without other means of access to medical care. |
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| Deductible | A fixed dollar amount during the benefit period - usually a year - that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles. ♦ Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission. ♦ Deductibles may differ if services are received from an approved provider or if received from providers not on the approved list. |
| Flexible spending accounts or arrangements (FSA) | * Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee’s share of insurance premiums or medical expenses not covered by the employer’s health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs. |
|  | Private Rooms.   * Flexible benefits plan (Cafeteria plan) (IRS 125 Plan) |
|  | At Nonparticipating Hospitals:   * If you are hospitalized in a nonparticipating facility, your copayment is based on HMSA’s maximum allowable fee for semi-private rooms. Also, you owe the difference between the facility’s private room charge and HMSA’s maximum allowable fee for semi-private rooms.   ***Exception***: If you are hospitalized for conditions identified by HMSA as conditions that require a private room, your copayment is based on HMSA's maximum allowable fee for private rooms. Also, you owe the difference between the facility's private room charge and HMSA's maximum allowable fee for private rooms. You may call HMSA for a list of these conditions. |
|  | Newborn nursery care. Covered for the baby's nursery care after birth in accord with the time periods specified later in this chapter under *Maternity and Newborn Length of Stay*. |
|  | ***Please note:*** This is the input with all the facilities |
| Flexible benefits plan (Cafeteria plan) (IRS 125 Plan) | Covered. |
| Fully insured plan | Covered. |
| Gatekeeper | Covered. |
| Group purchasing arrangement | Covered. |
| Association Health Plans | Covered, including but not limited to observation room and labor room. |
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| Health Care Plans and Systems | * Indemnity plan - A type of medical plan that reimburses the patient and/or provider as expenses are incurred. ♦ Conventional indemnity plan - An indemnity that allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred. ♦ Preferred provider organization (PPO) plan - An indemnity plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or no discounted charges from the providers. ♦ Exclusive provider organization (EPO) plan - A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation. |
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## Online Care

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| Physician-hospital organization | Alliances between physicians and hospitals to help providers attain market share, improve bargaining power and reduce administrative costs. These entities sell their services to managed care organizations or directly to employers. |

## Managed care plans

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| Managed care plans | Managed care plans generally provide comprehensive health services to their members, and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include: ♦ Health maintenance organizations (HMOs), ♦ Preferred provider organizations (PPOs), ♦ Exclusive provider organizations (EPOs), and ♦ Point of service plans (POSs).  Managed care provisions - Features within health plans that provide insurers with a way to manage the cost, use and quality of health care services received by group members. Examples of managed care provisions include: |
|  | Preadmission certification - An authorization for hospital admission given by a health care provider to a group member prior to their hospitalization. Failure to obtain a preadmission certification in non-emergency situations reduces or eliminates the health care provider’s obligation to pay for services rendered. ♦ Utilization review - The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during, or after the services are rendered |

## Physician Services

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| Maximum plan dollar limit | The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while covered under the health plan. ♦ Plans can have a yearly and/or a lifetime maximum dollar limit. ♦ The most typical of maximums is a lifetime amount of $1 million per individual. |
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| Maximum out-of-pocket expense | The maximum dollar amount a group member is required to pay out of pocket during a year. Until this maximum is met, the plan and group member shares in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, often up to a lifetime maximum. (See previous definition.) |
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| Medical savings accounts (MSA) | Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and a Medical Savings Account (MSA) is the ability under an MSA to carry over the unused funds for use in a future year, instead of losing unused funds at the end of the year. Most MSAs allow unused balances and earnings to accumulate. Unlike FSAs, most MSAs are combined with a high deductible or catastrophic health insurance plan |
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| Minimum premium plan (MPP) | A plan where the employer and the insurer agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services. |
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| Multiple Employer Welfare Arrangement (MEWA) | MEWA is a technical term under federal law that encompasses essentially any arrangement not maintained pursuant to a collective bargaining agreement (other than a State-licensed insurance company or HMO) that provides health insurance benefits to the employees of two or more private employers. Some MEWAs are sponsored by associations that are local, specific to a trade or industry, and exist for business purposes other than providing health insurance. Such MEWAs most often are regulated as employee health benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA), although States generally also retain the right to regulate them, much the way States regulate insurance companies. They can be funded through tax-exempt trusts known as Voluntary Employees Beneficiary Associations (VEBAs) and they can and often do use these trusts to self-insure rather than to purchase insurance policies. Other MEWAs are sponsored by Chambers of Commerce or similar organizations of relatively unrelated employers. These MEWAs are not considered to be health plans under ERISA. Instead, each participating employer’s plan is regulated separately under ERISA. States are free to regulate the MEWAs themselves. These MEWAs tend to serve as vehicles for participating employers to buy insurance policies from Statelicensed insurance companies or HMOs. They do not tend to self-insure. |
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