Uniform Glossary

The Summary of Benefits and Coverage (SBC) final regulations require group health plans and health insurance issuers to provide the Uniform Glossary in a common format and use terminology that is understandable by the average plan enrollee or individual covered under an individual policy.

The Uniform Glossary includes many commonly used health coverage and medical terms, but isn't a full list. These terms and definitions are intended to be educational and may be different from the terms and definitions for a plan. Some of these terms might not have exactly the same meaning when used in a policy or plan, and in any such case, the policy or plan governs. The glossary may not be modified by plans or issuers.

Examples of insurance-related terms to be defined are: co-insurance, co-payment, deductible, excluded services, grievance, appeal, non-preferred provider, out-of-network co-payment, out-of-pocket limit, preferred provider, premium, and UCR (usual, customary and reasonable) fees.

Examples of medical terms to be defined are: durable medical equipment, emergency medical transportation, emergency room care, home health care, hospice services, hospital outpatient care, hospitalization, physician services, prescription drug coverage, rehabilitation services, and skilled nursing care.

How to Access the Uniform Glossary

The Uniform Glossary may be reviewed and obtained at the following websites: The Center for Consumer Information & Insurance Oversight (CCIIO) at **www.cciio.cms.gov**, U.S. Department of Labor at **www.dol.gov/ebsa/healthreform**, and **www.healthcare.gov.** Paper copies of the Uniform Glossary are also available upon request.

Written Translation of the Uniform Glossary

Plans and issuers are also required to provide notices in a culturally and linguistically appropriate manner. This includes providing access to written translation of the Uniform Glossary in Spanish, Tagalog, Chinese, and Navajo for certain geographic areas. HHS will provide written translation of the Uniform Glossary in the above listed languages at the following websites: **www.cciio.cms.gov** and **www.dol.gov/ebsa/healthreform**.

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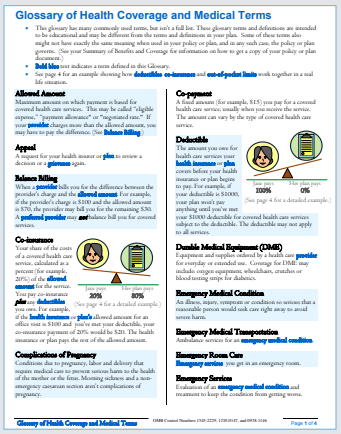
Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**)

Appeal
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing
When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may **not** balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an **emergency medical condition**.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

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6/12

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