CALIFORNIA DIALOGUE ON CANCER
Preventing Cancer & Saving Lives through Collaboration

"Key California Financial Cancer Resources"

Glossary of Terms

Term	Definition
Allowed amount, also referred to as **Eligible expense, Payment allowance, or Negotiated rate**	The **allowed amount** is the maximum amount that your insurance plan will cover for a service. For example, your insurance may have set the allowed amount to see a specialist at $200. If you have met your deductible, you will only pay a percentage of the allowed amount. The allowed amount is also sometimes referred to as "eligible expense," "payment allowance" or "negotiated rate
American with Disabilities Act (ADA)	The **American with Disabilities Act (ADA)** prohibits discriminating against people with disabilities, including people with cancer. The ADA requires that private employers with over 15 employees provide **reasonable accommodation** to employees with disabilities. This could include offering flexible hours, reduced work hours, accessible parking, a change in duties or work environment.
Annual deductible	An **annual deductible** is the amount you have to pay **out-of-pocket** each year, before your health insurance policy kicks in. This fixed dollar amount could be $500 or $5,000. Some plans have no deductible and will pay a percentage of your health care bills as soon as you are enrolled in the plan.
Appealing denials	If your health insurance plan refuses to cover a certain treatment, procedure or medication, you can **appeal the denial**. This means requesting that your health insurer review their decision again. It is highly recommended to appeal insurance denials, since it is common for denials to be overturned. You can ask a member of your health care team to help with the appeal. Organizations such as **Triage Cancer** can also help you with appeals.
Brand exception	Most insurance plans have a list of covered medications called a **formulary**. In some cases, the formulary will include cheaper generic drugs, but not the more expensive brand name drugs. If you need a medication that is not on the formulary list, you can request your insurer to cover the drug you want by requesting a **brand exemption**.
Brand-name drug	A **brand name drug** is a drug that is sold by a company that owns the patent for the drug. The company sells the drug by a specific name that is trademarked. Once the patent expires, other companies can produce a generic version of the drug under a different name, which has the same active ingredient

	as the brand-name drug. **Generic drugs** tend to be cheaper than the brand-name drug.
Charitable Foundation Copay Assistance	There are many charitable organizations dedicated to helping people with their copays, deductibles, and obtaining the medications they need. To get see if you can get some of your out-of-pocket costs covered, look up "**charitable foundation copay assistance**" to find organizations that can connect you to charitable organizations that can help with your out-of-pocket medical expenses.
Claims Assistance Counseling One-on-one help	Many organizations can provide **one-on-one counseling** to help you decide how to choose a health insurance plan, appeal a denial, challenge a medical bill, or understand your medical benefits and options. A non-profit that provides this type of counseling free of charge include **Triage Cancer. The Alliance of Claims Assistance Professionals (ACAP**) offers similar services for a charge.
Co-Insurance or Cost-Share	The percentage of a medical bill that the health insurance plan will pay is called **co-insurance** or **cost of share**. The remainder of the bill needs to be paid by you. The amount that you need to pay is called **patient liability**. For example, if you have an 80/20 plan, the insurance company pays 80% of your medical expenses (coinsurance) and you are responsible for 20% of your medical expenses, after paying your deductible.
Commercial Health Insurance	**Commercial health insurance plans** are those that are administered by nongovernment entities. Examples of commercial insurance companies are Kaiser Permanente, Blue Cross Blue Shield, United Health Care, and others.
Coordination of Benefits (COB) (understanding your denial)	When a person is covered by more than one health insurance plan, **coordination of benefits (COB)** is the process used to determine what each plan will pay. If you have both a primary and a secondary insurance policy, it's essential to complete and submit COB forms every year. Failing to complete these forms can result in claim denials.
Co-Payment	A **copayment** is the fixed dollar amount you pay when you get medical care. For example, when you visit the doctor's office you might have a $20 co-payment; if you go to see a specialist, you might have a $40 co-payment. You usually pay your co-payment at the time you get care.
Deductible	Some insurance plans have a **deductible**, which is a specific amount that you need to pay out of pocket before your insurance plan starts to cover your care.
Department of Fair Employment and Housing in California (DFEH)	The **DFEH** administers California state laws that prohibit harassment and discrimination in employment, housing and

	public accommodations. For more information go to http://www.dfeh.ca.gov or call (800) 884-1684.
Drug Manufacturer Copay Assistance	Some drug manufacturers offer **copay assistance** to reduce the **out-of-pocket** expenses for medications. You can access this benefit by obtaining a copay card through the drug manufacturer's website or by asking your healthcare provider or pharmacist about copay cards for the medications you are taking.
Eligibility requirements	Some health insurance plans may have certain conditions called **eligibility requirements** that must be met to offer coverage. For example, Medi-Cal insurance requires that a person's income be below a certain threshold.
Equal Employment Opportunity Commission (EEOC).	The **EEOC** investigates and tries to resolve issues of employment discrimination due to cancer, disability, race, religion and other factors. If you have faced employment discrimination, you can contact them to file a complaint.
Exclusive Provider Organizations (EPOs)	An **EPO** is a managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency). Typically, EPOs will not pay for any services obtained outside of the network.
Experimental or Investigational (understanding your denial)	Treatments deemed **experimental or investigational** by your insurance company may result in denials. Make sure to ask your provider to help when justifying these treatments.
Family Medical Leave Act (FMLA)	**FMLA** allows eligible employees to take up to 12 weeks per year to take care of serious medical issues for oneself or eligible family members (i.e., spouse, parent, or child).
Fee-for-service plans	**Fee-for-service** insurance plans pay for a portion of each medical service you receive. While these plans offer flexibility and choice in the doctors you can choose, they are often more expensive than other plans, such as **HMOs** or **PPOs**, that work with an established network of doctors.
Formulary	Most insurance plans have a list of covered medications called a **formulary**. In some cases, the formulary will include cheaper generic drugs, but not the more expensive brand name drugs. Understanding and using a plan's formulary can help you save money on medications. Some plans have formularies with two or more cost levels, known as tiers. The **co-payment** and **co-insurance** amounts will depend on the tier of the prescription drug you are taking. For example, a tier 1 drug may have a $10 **co-payment**, while a tier 5 **specialty drug** may have a 30% **co-insurance** amount.
Generic drugs	A **generic drug** contains the same chemical substance (active ingredient) as ***a* brand-name drug**, but is produced by a different company, often at a lower cost.
Guarantor	A **guarantor** on your medical bill is the person responsible for paying the bill. A guarantor can be the patient or it can

	be the person responsible for paying the bills, as in the case of a parent who is responsible for paying the bills of their children or spouse.
Health Maintenance Organizations (HMOs)	**HMOs** are health care organizations that contract with a specific list of doctors. In HMOs patients have a primary care doctor who is responsible for their care and for making referrals to specialists. HMOs are often less expensive than other options.
Independent Medical Review Program (IMR), also known as **External review.**	**An Independent Medical Review**, also known as an **external review**, is a process in which expert independent medical professionals are selected to review specific medical decisions made by the insurance company. The California Department of Insurance administers an IRE program that enables you to request an impartial appraisal of the decision made by your insurance company. Your insurer will no longer have the final say over whether to approve a treatment or pay a claim.
Independent Review Entity (IRE)	**An independent review entity (IRE)** is an outside organization that handles external medical reviews.
In-network providers	A provider network is a list of doctors, other health care professionals, hospitals, and healthcare facilities that an insurance plan contracts with to provide medical care to its members. These providers are called **in-network providers** and their services are provided at a discounted rate. Providers that are not on the list are called **out-of-network providers**.
Internal appeals	If you claim is denied or your insurance coverage is canceled, you can ask your insurance company to conduct a full and fair review of its decision. This is called an **internal appeal**. (You also have the right to take your appeal to an independent third party. This is called an **external appeal**.)
Mail-order pharmacies	If you prefer not to stop at your local drug store to pick up medications, you can get your medications sent to you by mail through **a mail-order pharmacy**. To set this up, have your doctor send your prescriptions to the mail order pharmacy that works with your insurance plan. Some local pharmacies, where you can go to pick up your medications, also provide mail-order benefits.
Medically necessary **Medical necessity**	When a claim for coverage is denied because your insurance company deems that the care is unnecessary or that an alternative treatment is sufficient, you can sometimes reverse the denial by showing that the care is **medically necessary**. You can ask your **provider** for help in doing so.
Mistakes (understanding your denial)	Medical bills are complex and errors in calculating the costs of your care can occur. If you suspect a **mistake** in billing, contact your **provider** to request that they resubmit your claim with correct information, and

	explain the resubmission to your insurance (Review your bills and don't be afraid to ask your **provider** for help.)
Monthly premium	The **monthly premium** is the amount you pay each month to your health insurance to have coverage. You pay this monthly expense regardless of whether or not you receive care.
Non-formulary drug exception request	If you would like to use a drug that is not covered by your insurance, you can request a **non-formulary drug exception.** This is a request asking that an exception be made to allow you to take the drug that is not on the **formulary** (the list of approved drugs).
Out-of-network providers	Certain insurance plans, such as HMOs or PPOs have a group of doctors that they contract with. These are referred to as **in-network providers**. Doctors who are not contracted with the insurance company are known as **out-of-network providers**. The rates for out-of-network providers are higher and you will need to pay more **out-of-pocket** to see them.
Out-of-Pocket Maximum	Your **out-of-pocket maximum** is the total amount that you will need to pay for your treatment before the insurance will cover the full cost of the rest of your care for the remainder of the year. If you have an out-of-pocket maximum of $6000, for example, the insurance plan will pay 100% of your medical expenses once you have spent $6000 of your own money. (Many insurance companies only count expenses towards the out-of-pocket maximum that are from ***in-network providers***. Also, some employer-sponsored plans may exclude **co-payment**s from your out-of-pocket maximum).
Patient liability	**Patient liability** is the amount of money that you owe on your medical bill that is not covered by insurance. For example, if you have an 80/20 plan, the insurance company will pay 80% of your medical expenses and you will be liable for 20% of the allowed amount, after the **deductible** has been paid.
Pre-Authorization (understanding your denial)	Your health insurance may need you to get **pre-approval** or **pre-authorization** from your health care provider for certain procedures in order to cover the cost of the treatment or procedure. It is important to note what services require pre-authorization before you get care. If you haven't gotten a service pre-authorized, you can ask your insurance company to retroactively authorize it.
Preferred Provider Organization (PPO)	A **PPO health insurance plan** is one that gives you flexibility to see providers that are in-network as well as providers that are out-of-network. If you see providers that are in-network (generally local), then a large portion of the

	cost of care (80-100%) will be covered (once you meet your deductible). If you choose to go out-of-network and see providers in a different health care system or out-of-state, the plan will pay a lower percentage of your bill.
Prescription drug coverage	**Prescription drug coverage** is when your health insurance plans helps to pay for prescription drugs. Most health care plans are required to cover prescription drugs.
Preventive services	**Preventive services** are health care services that either prevent health care conditions from occurring or address them before they become serious. Some health plans cover some of these services at no extra costs. Examples of preventive services include vaccinations and cancer screenings such as mammograms and colonoscopies.
Provider (medical)	A health care **provider** is a member of the health care team that is involved in health care delivery, such as a doctor, nurse, medical assistant, and other members of the care team.
Reasonable Accommodation - Employment	**A reasonable accommodation** is a change that an employer can make to ensure that a qualified individual with a disability can apply for a job and/or perform the essential functions of their job. The accommodations are considered "reasonable" if they don't create undue hardship on, or pose a direct treat to, the employer. Examples of changes include working from a different location; extra breaks, a more flexible or reduced work schedule; or using technology, such as special software to that magnifies the computer screen for employees with vision problems.
Retail pharmacies	A place where you go to pick up your medical prescriptions.
Service Not Covered (understanding your denial)	If your insurance company says your **service is not covered**, check your policy to see if the service is listed as "excluded." If not, contact your insurance company and ask for more information about the denial. They may claim the service was unnecessary. If so, you may be able to appeal the decision. call your **provider** and ask for help showing that the care is **medically necessary**.
Specialty drugs	**Specialty drugs** are high-cost prescription drugs that are complex medications to produce. Many drugs for cancer are considered specialty drugs. Specialty drugs are marked with an S, SCN or LLD symbol on the drug formulary.
Specialty pharmacies	**Specialty pharmacies** provide high-cost, complex medications known as **specialty drugs**.
Step therapy	Step therapy is when your insurance company requires you to take certain steps before they will pay for a certain medication. This often means requiring patients to try a generic or lower cost drug before getting a brand-name or more expensive drug. If the lower cost drug doesn't work or

	causes a bad reaction, patients are allowed to "step up" to another medicine. If your insurance company uses step therapy and you want to use a specific drug that is higher up the chain, it is important to work with your health care team to show that taking a specific drug is medically necessary for you and why the insurance company should make an exception to their process.
Tier exception	Some insurance plans have tiers for the drugs that they cover, where the cheaper generic drugs are on a lower tier and are provided at a lower cost. If you can demonstrate that a desired medication at a higher tier is **medically necessary**, a **tier exception** can be made, so that the desired drug can be offered as if it were in a lower tier, reducing your **out-of-pocket** costs.
Timely Submission (understanding your denial)	Insurance plans require bills to be submitted to them within a certain time frame (**timely submission)**. Claims that are submitted after the allowed time frame may be denied. If your provider is within network, fixing this error usually only requires a phone call to your **provider**. (Generally, providers are in charge of submitting claims, so they are held accountable for this mistake.)

CDOC Survivorship Workgroup Member Organizations

- American Cancer Society
- Cancer Kinship
- Cancer Support Community San Francisco Bay Area
- Disability Rights Legal Center's Cancer Legal Resource Center (CLRC)
- Health Options
- Latinas Contra Cancer
- Patient& Research Advocate
- Teen Cancer America
- The Leukemia & Lymphoma Society, Southern California & Hawaii Region
- Touro University
- Tower Cancer Research Foundation
- Triage Cancer
- UC Davis Medical Center, Sutter Health
- UCLA David Geffen School of Medicine
- UCSF
- USC Norris Cancer Hospital, Keck Hospital of USC
- Wellness Within Cancer Support Services
- Zero Breast Cancer

References:

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