SeaGen Secure™

Patient Assistance and Reimbursement Support

Glossary

Below you will find brief definitions for some common healthcare terms and some that pertain solely to ADCETRIS® (brentuximab vedotin). Please click the letter that matches the first letter of the word for which you are searching.

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Accredited (Accreditation):
A "seal of approval" for healthcare facilities. Being accredited means that a facility has met certain quality standards. These standards are set by private, nationally recognized groups that check on the quality of care at healthcare facilities.

Accumulation Period:
Time frame within a policy period in which deductible and out-of-pocket amounts are calculated. For most health insurance policies, the accumulation period is a calendar year.

Administrative Services Only (ASO):
An arrangement in which an employer hires a third party to deliver employee benefit administrative services to the employer. These services typically include health claims processing and billing. The employer bears the risk for healthcare expenses under an ASO plan.

Admitting Physician:
The doctor responsible for admitting you to a hospital or other inpatient health facility.

After Care:
The care or follow-up treatment needed by a patient who has recently undergone surgery, been involved in an accident or experienced an illness requiring hospitalization.

Ambulatory Care:
All types of health services that do not require an overnight hospital stay.

Ancillary Services:
Services, other than those provided by a physician or hospital, that are related to a patient's care, such as laboratory work, X-rays and anesthesia.

Appeal:
Request made to a payer to reconsider a decision, such as a claim denial or denied prior authorization request. Most appeals must be submitted in writing within a specified period.

Assignment of Benefits:
When an insured person assigns benefits, they sign a document allowing the hospital or doctor to collect health insurance benefits directly from the health insurance company. Otherwise, the insured person pays for the treatment and is later reimbursed by the health insurance company.

Beneficiary:
A person eligible for benefit under a health insurance policy.

Benefit:
Amount payable by the insurance company to a claimant, assignee or beneficiary when the insured suffers a loss.

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Benefit Cap:
Total dollar amount that a payer will reimburse for covered healthcare services during a specified period, such as one year.

BI (Benefit Investigation):
ADCETRIS BIs are conducted by SeaGen Secure at the request of the provider or patient. BIs include full coverage information for ADCETRIS, including the patient's co-insurance, OOP and any possible prior authorizations (PAs). Results are faxed to the office within 2 business days.

Board Certified:
A physician who has passed examinations given by a medical specialty group and who has, as a result, been certified as a specialist in this area of practice.

Broker:
A licensed legal representative of the policyholder who negotiates with an insurance company on behalf of a customer but is paid a commission by the insurance company.

Capitation:
Capitation represents a fixed monthly dollar amount that a Health Maintenance Organization (HMO) pays to a group of healthcare providers who have contracted with the HMO. The amount of this fixed dollar amount depends on the number of HMO enrollees who have chosen this group of healthcare providers for primary care services under the HMO plan. This fixed dollar amount does not vary with how much HMOs enrollees use (or don't use) services offered by this group of HMO providers. Not all HMOs utilize capitation payments.

Care Plan:
A written plan for one's healthcare.

Case:
A case represents an ADCETRIS patient in the SeaGen Secure database.

Case Management:
A process whereby an insured person with specific healthcare needs is identified and a plan that efficiently utilizes healthcare resources is designed and implemented to achieve the optimum patient outcome in the most cost-effective manner.

Case Manager:
A nurse, doctor or social worker who arranges all services that are needed to give proper healthcare to a patient or group of patients.

Catastrophic Illness:
A very serious and costly health problem that could be life-threatening or cause lifelong disability. The cost of medical services alone for this type of serious condition could cause financial hardship.

Centers of Excellence:
Hospitals that specialize in treating particular illnesses or performing particular treatments, such as cancer or organ transplants.

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Claim:
Form submitted to a payer (by a healthcare provider or patient) to request payment for items or services.

Clinical Practice Guidelines:
Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.

Co-insurance:
Cost-sharing arrangement between an insured person and the health insurance company in which the insured person is required to pay a percentage of the cost for the healthcare services received. Co-insurance typically applies after satisfaction of a deductible. For example, 80% co-insurance may apply after a $500 deductible has been satisfied.

Compendium:
A comprehensive listing of FDA-approved drugs and biologics or a comprehensive listing of a specific subset of drugs and biologics in a specialty compendium; for example, a compendium of anticancer treatment. A compendium includes a summary of the pharmacologic characteristics of each drug or biologic and may include information on dosage, as well as recommended or endorsed uses in specific diseases. A compendium is indexed by drug or biologic.

Consolidated Omnibus Budget Reconciliation Act (COBRA):
The Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA, requires group health plans with 20 or more employees to offer continued health coverage for employees and their dependents for 18 months after the employee leaves the job. Longer durations of continuance are available under certain circumstances. If a former employee opts to continue coverage under COBRA, the former employee must pay the entire premium, plus a 2% administration charge.

Contract Year:
The period of time from the effective date of the contract to the expiration date of the contract. A contract year is typically 12 months long, but not necessarily from January 1 through December 31.

Coordinated Care:
Links the treatments or services necessary to obtain an optimum level of medical care required by a patient and provided by appropriate providers. It is also another term for “managed care” used by federal government officials.

Coordination of Benefits (COB):
A provision in the contract that applies when a person is covered under more than one health insurance plan. It requires that payment of benefits be coordinated by all plans to eliminate over-insurance or duplication of benefits.

Co-payment (Co-pay):
Co-payment is a predetermined fee, in addition to what health insurance covers, that an individual pays for healthcare services. For example, a PPO may require a $20 co-payment for normal services delivered during a physician office visit.

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Cost Sharing:
This occurs when the users of a healthcare plan share in the cost of medical care. Deductibles, co-insurance and co-payments are examples of cost sharing.

Covered Benefit:
A health service or item that is included in a health plan and that is partially or fully paid by the health plan.

Covered Charges/Expenses:
Most insurance plans, whether they are PPOs or HMOs, do not pay for all services. Some may not pay for prescription drugs. Others may not pay for mental health care. Covered services are those medical procedures for which the insurer agrees to pay. They are listed in the policy.

Credentialing:
The process used by health insurance companies to examine and verify the medical qualifications of healthcare providers who want to participate in the PPO or HMO network.

Creditable Coverage:
Any previous health insurance coverage that can be used to shorten the preexisting condition waiting period. See “HIPPA.”

Critical Access Hospital:
A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Current Procedural Terminology (CPT):
A system of terminology and coding developed by the American Medical Association (AMA) that is used for describing, coding and reporting medical services and procedures.

Custodial Care:
Personal care, such as bathing, cooking and shopping.

Deductible:
Cost-sharing arrangement between an insured person and a health insurance company in which the insured person will be required to pay a fixed dollar amount of covered expenses each year before the health insurance company will reimburse for covered healthcare expenses. Generally, an insured person is responsible for a deductible each calendar year.

Denial of Claim:
Refusal by a health insurance company to honor a request by an individual (or his or her provider) to pay for healthcare services obtained from a healthcare professional.

Dependent:
A covered person who relies on another person for support or obtains health coverage through a spouse or parent who is the covered person under a health plan.

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Designated Facility:
A facility that has an agreement with a health insurance plan to render approved services. (Organ transplants are the most common example.) The facility may be outside a covered person's geographic area.

Discharge Planning:
Medical personnel of a health plan working with the attending physician and hospital staff to assess alternatives to hospitalization, evaluate appropriate settings for care and arrange for the discharge of a patient, including planning for subsequent care at home or in a skilled nursing facility. The goal is to determine when patients are ready to go home and to provide a more comfortable, cost-efficient setting for continued treatment.

Dis-enroll:
Ending a person's healthcare coverage with a health plan.

DRG (Diagnostic Related Group):
A Medicare-developed healthcare cost schedule through which medical service providers are assigned a uniform payment for specific services.

Effective Date:
The date health insurance coverage begins.

Eligible Dependent:
A dependent of a covered person (spouse, child or other dependent) who meets all requirements specified in the contract to qualify for coverage and for whom premium payments are made.

Eligible Expenses:
The lower of the reasonable and customary charges or the agreed upon health services fee for health services and supplies covered under a health plan.

Employee Assistance Programs (EAPs):
Mental health counseling services that are sometimes offered by insurance companies or employers. Typically, individuals or employers do not have to directly pay for services provided through an EAP.

Enrollee:
The person who is the primary insured. Under an individual or family policy, this person is the applicant. Under an employer-sponsored group health policy, this person is the employee.

Episode of Care:
The healthcare services given during a certain period of time, usually during a hospital stay.

Evidence of Insurability:
Proof of physical condition. This may be provided through physician records or by the results of an examination.

Exclusion Period:
A period of time when an insurance company can delay coverage of a preexisting condition. Sometimes this is called a preexisting condition waiting period.

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Exclusions and Limitations:
Medical services that are either not covered or limited in benefit by a health insurance policy.

Explanation of Benefits (EOB):
Statement sent by health plans to persons who have experienced a claim under the health plan. The explanation of benefits details the charges for the services received, the amount the health insurance company will pay for those services and the amount the insured person will be responsible for paying.

Fee-for-Service:
A payment system for healthcare in which the provider is paid for each service rendered rather than a prenegotiated amount for each patient.

Fee Schedule:
A complete listing of fees used by health plans to pay doctors or other providers.

Flexible Benefit Plan:
A benefits package allowing an employee to choose from a range of benefit choices.

Flexible Spending Account (FSA):
An employee benefits cash account from which nontaxable withdrawals can be made to fund eligible expenses defined by the employer-sponsored plan. The FSA is funded by reductions in salary prior to calculation of federal income and social security taxes.

Formulary:
A list of certain drugs and their proper dosages. Under most health plans, better benefits are provided for formulary drugs than are provided for nonformulary drugs.

Free-Look Period:
Typically a 10-day period during which a newly insured person can cancel a policy and receive a full refund of paid premium.

Full-Time Student:
Under a health plan, an eligible dependant child student (typically age 19 or older) who meets the health plan's criteria for "full-time." Such criteria normally include minimum credit hour requirements (such as 12 credit hours in a semester) and a maximum age (age 23 is typical).

Gag Rule Laws:
Special laws that make sure that health plans let doctors provide their patients with complete healthcare information. This includes information about treatments not covered by the health plan.

Grievance:
Request made to a health plan to reconsider coverage of a healthcare service that the health plan has not interpreted to be a covered benefit.

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Group Health Plan:
A health plan that provides health coverage to employees and their families and is supported by an employer or employee organization.

Guaranteed Issue:
Under guaranteed issue, a health insurance company or HMO must issue coverage to an applicant regardless of prior medical history. In Illinois and Indiana, small employers (defined as 2 to 50 employees) cannot be refused coverage for their employees regardless of the medical history of one or more employees.

HCFA Common Procedure Coding System (HCPCS):
Name given to CPT codes (Level I), alphanumeric codes (Level II) and local codes (Level III) used by payers and providers for billing purposes. Within the industry, most refer to Level II national codes as HCPCS codes.

HCPCS Codes:
These are 5-digit alphanumeric codes that are used to represent all services, supplies and drugs billed to insurance companies. There are many different HCPCS codes, but common codes are J codes, representing non–self-administered drugs or biologics. The code for ADCETRIS will be assigned a permanent J code that will be effective January 1, 2013.

Healthcare Provider:
A doctor, hospital, laboratory, nurse or anyone who delivers medical or health-related care.

Health Employer Data and Information Set (HEDIS):
A set of standard performance measures that provides information about the quality of a health plan. These measures are used to compare managed care plans.

Health Insurance Portability & Accountability Act (HIPAA):
A law passed in 1996, which is also called the “Kassebaum-Kennedy” law. This law expanded healthcare coverage for people who have lost their job or moved from one job to another. HIPAA protects people who have preexisting medical conditions and/or problems, based on past or present health, in getting health insurance coverage.

Health Maintenance Organization (HMO):
Prepaid health plans that cover doctors’ visits, hospital stays, emergency care, surgery, preventive care, checkups, lab tests, X-rays and therapy. In an HMO, one must choose a primary care physician who coordinates all care and makes referrals to any specialists that may be required. In an HMO, one must use the doctors, hospitals and clinics that participate in the plan’s network. No benefits are paid for nonemergency benefits provided outside the HMO network.

Health Reimbursement Arrangement (HRA):
A tax-advantaged employee health spending account funded and owned by the employer. Funds remaining in the account at year-end revert to the employer. For the employee, HRAs are a “use it or lose it” proposition.

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Health Savings Account (HSA):
Operating similarly to HRAs, HSAs are tax-advantaged savings accounts for healthcare services. A person must enroll in a qualified high-deductible health plan (HDHP) before he or she can establish an HSA.

High-Deductible Health Plan (HDHP):
A person must be enrolled in a qualified high-deductible health plan before he or she can establish a Health Savings Account (HSA). Not all high-deductible health plans qualify for purposes of establishing HSA eligibility. A qualified HDHP benefit design must conform to various federally mandated requirements, such as a minimum $1,000 deductible and a lack of first-dollar benefit provisions.

Home Healthcare:
Services given at home to aged, disabled, sick or convalescent individuals not needing institutional care. The most common types of home care are visiting nurse services and speech, physical, occupational and rehabilitative therapy. These services are provided by home health agencies, hospitals or other community organizations.

Hospice Care:
Care for the terminally ill and their families, in the home or a nonhospital setting, that emphasizes alleviating pain rather than a medical cure.

Hospital Care:
Reimbursement for both inpatient and outpatient medical care expenses incurred in a hospital. Inpatient benefits include charges for room and board, charges for necessary services and supplies sometimes referred to as hospital extras, other hospital extras, miscellaneous charges and ancillary charges. Outpatient benefits include surgical procedures, rehabilitative therapy and physical therapy.

Hospital-Surgical Coverage:
A form of health insurance that offers coverage of certain costs related to hospitalization and surgical procedures. A hospital-surgical plan does not cover other types of medical services, such as physician office visits and outpatient prescription drugs.

ICD-9-CM Codes:
These are diagnosis codes used by providers when billing claims. Common ICD-9-CM codes when billing ADCETRIS include 174.0 through 175.9, representing breast cancer. In the future, ICD-9 will be replaced by ICD-10 diagnosis codes.

Impaired Risk:
An insurance applicant who has preexisting poor health or is in substandard physical condition, is engaged in dangerous activities or has a hazardous occupation.

Incurral Date:
The date on which healthcare services are provided to a covered person. The incurral date, not the date on which the insurance company pays a healthcare claim, is the critical date in determining health insurance benefits. For example, a health insurance company will not pay a claim for healthcare services incurred prior to the effective date of the health insurance coverage.

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Indemnity Health Plan:
Indemnity health insurance plans are also called "fee-for-service." These are the types of plans that primarily existed before the rise of HMOs and PPOs. With indemnity plans, the individual pays a predetermined percentage of the cost of healthcare services, and the health plan pays the other percentage. For example, an individual might pay 20% for services while the insurance company pays 80%. The fees for services are defined by the healthcare providers and vary from physician to physician and hospital to hospital.

Independent Practice Association (IPA):
An IPA is a type of HMO in which care is provided by independent physicians who contract with the HMO. This contrasts with the "staff model" HMO, in which physicians are employees of the HMO.

Inpatient Care:
Healthcare received during an overnight hospital stay.

Insured:
A person who has obtained health insurance coverage under a health insurance plan.

Lapse:
Termination of insurance for nonpayment of premium.

Lifetime Maximum:
A cap on the benefits paid for the duration of a health insurance policy. Many policies have a lifetime limit of $5 million, which means the insurer agrees to cover up to $5 million in covered services over the life of the policy. Once the $5 million maximum is reached, no additional benefits are payable.

Limited Policy:
A policy that covers only specified accidents or sicknesses (eg, a cancer policy).

Major Medical:
Health insurance coverage for expenses associated with hospital confinements, surgeries and/or medical conditions requiring a broad range of medical services and supplies.

Managed Care:
An organized way to manage costs, use and quality of the healthcare system. The major types of managed care plans are health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Master Policy:
The group insurance policy that explains coverage to all members of the group.

Medicaid:
Federal and state health insurance program for low-income individuals who meet established eligibility criteria (programs vary from state to state).

Medical Necessity:
Medical information justifying that the service rendered or item provided is reasonable and appropriate for the diagnosis or treatment of a medical condition or illness.

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Medical Savings Account (MSA):
A tax-advantaged personal savings account used in conjunction with a high-deductible health plan. Individuals can contribute money to this account on a pretax basis to set aside money for qualified medical care and expenses, including annual deductibles and co-payments.

Medically Necessary:
Many insurance policies will pay only for treatment that is deemed “medically necessary” to restore a person’s health. Medically necessary may include stipulations that the drug, biologic, device, etc, be given only for FDA-approved indications. For instance, many health insurance policies will not cover routine physical exams or plastic surgery for cosmetic purposes.

Medicare:
Federal health insurance program for the elderly (age 65 and older), certain disabled individuals and those with end-stage renal disease. Medicare is administered by the Center for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA).

Medicare Supplement:
A supplemental insurance policy to help cover the difference between approved medical charges and benefits paid by Medicare. These plans are also known as “Medigap” plans.

Medigap:
A supplemental insurance policy to help cover the difference between approved medical charges and benefits paid by Medicare. These plans are also known as “Medicare supplement” plans.

Misrepresentation:
Lying or misleading an insurance company about the facts affecting a policy. Misrepresentation is grounds for voiding a policy.

Morbidity:
A mathematical representation of the occurrence of illnesses in a specific classification of people.

National Association of Insurance Commissioners (NAIC):
A national organization of state officials charged with regulating insurance. NAIC was formed to promote national uniformity in insurance regulations.

National Committee for Quality Assurance (NCQA):
A national group responsible for devising and monitoring quality measurements and standards for healthcare entities.

National Drug Code (NDC):
Numerical coding system for drug identification. NDC numbers are assigned by the Food and Drug Administration (FDA) and are typically used to bill payers for the drugs provided to healthcare beneficiaries. The NDC for ADCETRIS for billing is 51144-0050-01.

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Network:
Groups of physicians, hospitals and other healthcare providers working with the health plan to offer care at negotiated rates.

Network Provider:
Physicians, hospitals or other providers of medical services that have agreed to participate in a network, to offer their services at negotiated rates and to meet other negotiated contractual provisions. Also called "participating provider."

Noncancelable Policy:
A policy that guarantees you can receive insurance, as long as you pay the premium. It is also called a guaranteed renewable policy.

Nonrenewable Policy:
An insurance policy that cannot be renewed or continued after its expiration date.

Open Enrollment:
A period each year during which employees have an opportunity to change their employer-provided healthcare coverage. They can usually choose among various plans from different health insurance providers.

Out-of-Network (OON):
Healthcare services received outside the HMO or PPO network. OON services are typically not covered or reimbursed unless the patient is referred by a participating HMO or PPO provider.

Out-of-Plan:
This phrase usually refers to physicians, hospitals or other healthcare providers who are considered nonparticipants in an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered or may be covered at a reduced benefit level.

Out-of-Pocket Costs:
Insured healthcare costs for which one is responsible because of the application of deductibles, co-insurance and co-payments.

Out-of-Pocket Maximum:
Total dollar amount an insured will be required to pay for covered medical services during a specified period, such as one year. The out-of-pocket maximum may also be called the stop-loss limit or catastrophic expense limit.

Participating Provider:
A healthcare provider who has been contracted to render medical services or supplies to insured persons at a prenegotiated fee. Providers include hospitals, physicians and other medical facilities that are part of a PPO or HMO network.

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Permanent Insurance:
Coverage that can be continued relatively indefinitely (such as to age 65 for most permanent health insurance policies) as long as the policyholder makes scheduled premium payments and refrains from actions that would invalidate the policy (such as misrepresentations on the application).

Policy:
The insurance agreement or contract.

Policyholder:
The insured person named on the insurance policy.

Policy Year:
The twelve-month period beginning with the effective date or renewal date of the policy.

Portability:
The ability for an individual to transfer from one health insurer to another with regard to preexisting conditions or other risk factors.

Preadmission Review:
A review of an individual's healthcare status or condition prior to an individual being admitted to a hospital or inpatient healthcare facility. Preadmission reviews are often conducted by case managers or insurance company representatives (usually nurses) in cooperation with the individual, his or her physician or healthcare provider and hospitals.

Preadmission Testing:
Medical tests that are completed for an individual prior to being admitted to a hospital or inpatient healthcare facility.

Preauthorization:
Under a preauthorization provision of a health insurance policy, the insured or their provider must contact the health insurance company prior to a hospitalization, surgery or drug administration and receive authorization for the service. When a preauthorization is not received, benefits will be reduced or often not covered.

Precertification:
This is a requirement that an insured person or their provider contact the health insurance company and advise them that a doctor has stated certain medical treatment is required. This is done before receiving treatment from the doctor or hospital. A health insurance policy will normally list the medical conditions that require precertification before receiving treatment. When precertification is not received, benefits will be reduced or often not covered.

Preexisting Condition:
A health problem that existed before the date the insurance policy became effective. Each health insurance company uses its own particular definition of preexisting condition. However, the following statement is in line with most insurance company provisions: "A preexisting condition is a medical condition that would cause a normally prudent person to seek treatment during the twelve months prior to the beginning of coverage."

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Preferred Provider Organization (PPO):
A network of healthcare providers with which a health insurer has negotiated contracts for its insured population to receive health services at discounted costs. Healthcare decisions generally remain with the patient, as he or she selects providers and determines his or her own need for services. Patients have financial incentives to select providers within the PPO network.

Premium:
The amount you or your employer pays in exchange for health insurance coverage.

Preventive Care:
An approach to healthcare that emphasizes preventive measures and health screenings such as routine physicals, well-baby care, immunizations, diagnostic lab and X-ray tests, Pap smears, mammograms and other early-detection testing. The purpose of offering coverage for preventive care is to diagnose a problem early when it is less costly to treat, rather than late in the stage of a disease when it is much more expensive or too late to treat.

Primary Care Physician (PCP):
Under a health maintenance organization (HMO) plan, the primary care physician is usually an insured person's first contact for healthcare. This is often a family physician, internist or pediatrician. A primary care physician monitors patient health, treats most patient health problems and refers patients, if necessary, to specialists.

Prior Authorization (PA):
A prior authorization is a requirement that services or drugs be approved by a private payer or Medicaid prior to coverage and subsequent reimbursement. PAs are payer-specific but can usually be obtained by phone, fax or Web. PAs are often handled within 24-48 hours by a payer but could take longer depending on the service or drug. Medicare does not require prior authorization or precertification for any drug (except under Part D), service or covered benefit.

Provider:
Any person (doctor or nurse) or institution (hospital, clinic or laboratory) that provides medical care.

Qualifying Event:
An occurrence (such as death, termination of employment, divorce, etc) that changes an employee's eligibility status under a group health plan. The term is most frequently used in reference to COBRA eligibility.

Reasonable and Customary (R&C) Charge:
A term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is generally considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community. "Reasonable and Customary (R&C) Charge" essentially means the same thing as "Usual and Customary (U&C) Charge."

Referral:
An OK from the primary care physician for the patient to see a specialist or get certain services. In many HMO plans, the insured person needs to get a referral before they get care from anyone except the primary care physician. If the referral is not received, the HMO may not cover resulting expenses.

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Renewal:
A continuation of an insurance policy on revised terms, such as adjusted health insurance rates.

Rider:
An attachment, amendment or endorsement to an insurance policy.

Risk:
For a health insurance company, risk is the chance of loss, the degree of probability of loss or the amount of possible loss. For an individual, risk represents such probabilities as the likelihood of surgical complications, medications' side effects, exposure to infection or the chance of suffering a medical problem because of a lifestyle or other choice. For example, an individual increases his or her risk of getting cancer if he or she chooses to smoke cigarettes.

Schedule of Benefits and Exclusions:
A health insurance listing of the benefits that are covered under the policy as well as services that are not provided under the policy.

Second Surgical Opinion:
This is an opinion provided by a second physician when one physician recommends surgery to an individual. Most health insurance policies cover second surgical opinions.

Self-Insured (Self-Administered):
The self-insured employer assumes risk for healthcare expenses in a plan that is self-administered or administered through a contract with a third-party organization. This form of coverage is regulated by the Employee Retirement Income Security Act of 1974. Hence, self-insured health plans fall under federal, rather than state, regulation.

Service Area:
The area where a health plan accepts members. For HMOs, it is also the area where services are provided. A health plan may terminate coverage for persons who move out of the plan's service area.

Short-Term Medical Insurance:
Temporary major medical coverage designed to fill "gaps" in traditional medical coverage. Short-term plans typically last no longer than one year and cannot be renewed.

Skilled Nursing Facility (SNF):
A licensed institution that provides regular medical care and treatment to sick and injured persons. Daily medical records are kept and patients are under the care of a licensed physician.

Special Benefit Networks:
Provider networks for particular services, such as mental health, substance abuse or prescription drugs.

Staff Model:
Staff model is a type of HMO in which care is provided by physicians who are employees of the HMO. This contrasts with the "independent practice association (IPA)" HMO, in which independent physicians contract with the HMO.

SeaGen Secure™

Patient Assistance and Reimbursement Support

Glossary

Below you will find brief definitions for some common healthcare terms and some that pertain solely to ADCETRIS® (brentuximab vedotin). Please click the letter that matches the first letter of the word for which you are searching.

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Standard Industrial Classification (SIC):
Coding of businesses by their product or service. This classification is used in group insurance in determining rates for various industries.

State Insurance Department:
An administrative agency that implements state insurance laws and supervises (within the scope of these laws) the activities of insurance companies operating within the state.

State-Mandated Benefits:
Benefits for a variety of medical conditions that a given state requires of health insurance policies sold in that state.

Stop-Loss Provisions:
A limit in a health insurance policy that provides for 100% payment of expenses after total patient out-of-pocket expenses exceed a certain contractual dollar amount.

Third-Party Payer:
Any payer of healthcare services other than the insured person. This can be an insurance company, HMO, PPO or the federal government.

Underwriting:
The act of reviewing and evaluating prospective insured persons for risk assessment and appropriate premium.

Urgent Care:
Healthcare provided in situations of medical duress that have not reached the level of emergency. Claim costs for urgent care services are typically much less than for services delivered in emergency rooms.

Usual and Customary (U&C) Charge:
A term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is generally considered to be usual if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community. “Usual and Customary (U&C) Charge” essentially means the same thing as “Reasonable and Customary (R&C) Charge.”

Utilization Review:
A mechanism by which the appropriateness, necessity and quality of healthcare services are monitored by both insurers and employers.

Waiting Period:
A period of time when the health plan does not cover a person for a particular health problem.