Suitable for all Admission packets, revised: June 2016

Glossary of Health Insurance Terms

Federal Poverty Limit
The federal poverty level (FPL) is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. All public health insurance programs, such as Medi-Cal or Covered CA define eligibility income limits as some percentage of FPL.

Universal Method to Determine Ability to Pay (UMDAP)
Financial Intake Procedure unique to the Mental Health system by which every client's income, property and basic household expenses are captured to determine the sliding fee rate s/he may be billed for services provided by *Behavioral Health and Recovery Services*.

Zero UMDAP
Applies to BHRS clients whose expenses exceed their income and/or who have no countable income in their own, therefore excluding her/him from the responsibility of paying a sliding fee rate for services received within the BHRS network of care. Does not apply to any other medical, dental or vision services provided by San Mateo County's Health Services (including the San Mateo Medical Center (SMMC)).

Medi-Cal Aid Code
Medi-Cal has more than 20 different programs that allow for different income limits and/or are only available for recipients within certain age groups and/or eligibility categories. Each program has a unique two-digit or letter/digit identifier that allows for the correct billing of provided services. Certain Aid Codes cover the same benefits, others are unique and only cover a particular type of treatment, e.g. substance abuse or Tuberculosis treatment.

Medi-Cal Share of Cost
An accumulative monthly deductible that everyone, whose income is above the applicable State & federal income limits for free Medi-Cal, has to pay for services before Medi-Cal pays for the remainder of any outstanding bills for medical, dental, vision and mental health services. A Share of Cost can be met by the first service received in a month, or may not be met through all services received by the last day of the month depending on its amount. It resets at the first of each month to the same fixed amount. Share of Cost can be recalculated at any time when there is a change in a Medi-Cal recipient's income information, but can usually only be applied from the current month forward.

Fullscope Medi-Cal versus Restricted Medi-Cal

Fullscope Medi-Cal allows full access to all Medi-Cal covered services. Restricted Medi-Cal only allows access to emergency care at a hospital and covers other restricted medical services for pregnant women or for the elderly who reside in a Long-Term Care facility. Eligibility for fullscope Medi-Cal is granted based on citizenship or lawful immigration status. If you are unsure if your immigration status entitles you to full access to all Medi-Cal services check with the Legal Aid Society of San Mateo's LIBRE program.

MAGI Medi-Cal
Modified Adjusted Gross Income (MAGI) Medi-Cal is a new Medi-Cal program that was implemented as part of the rollout of the Affordable Care Act in California since January 2014 and allows all Californians, even single or married childless adults with monthly incomes under 138 % FPL to qualify for Medi-Cal coverage without having to meet other certain eligibility criteria such as being disabled or being a single parent. The countable income is also based on the true taxable income reported on the annual income tax return rather than on a particular, complicated income formulary as used for traditional Medi-Cal.

Intra-County Transfer
Only applies to Medi-Cal recipients. Medi-Cal regulations demand that any active recipient who moves from one County to another within California must be kept on the same Medi-Cal program until the next annual redetermination, even if the move involves a change in income or property. The transfer can take up to 60 days from the day the new address has been notified to the County from where the move originates. No new application in the County the recipient transfers to needs to be filed and/or verifications need to be provided, unless it would benefit the recipient.

Health Plan of San Mateo (HPSM)
The Health Plan of San Mateo administers the following public health insurance/coverage programs in San Mateo County: Medi-Cal, 250 % Working Disabled program, CareAdvantage, ACE, Healthy Kids, Health Worx. The Health Plan determines the formulary for covered prescriptions and maintains a provider network that differs by program. It can authorize all treatment services, except for mental health and substance use treatment services, and functions as the billing entity between the State, County and any private provider within the networks. HPSM does not determine eligibility for any of the above programs. Final eligibility determination is done by the County's Human Services Agency and/or the SMMC's Health Coverage Unit.

Health Maintenance Organization (HMO)
Health maintenance organizations represent "pre-paid" or "capitated" insurance plans in which individuals or their employers pay a fixed monthly fee for services instead of a separate charge for each visit or service. The monthly fees remain the same, regardless of types or levels of services provided. Services are provided by physicians who are employed by, or under contract with, the HMO. HMOs vary in design. Depending on the type of the HMO, services may be provided in a central facility, or in a physician's own office (as with IPAs.) In San Mateo County the Health Plan of San Mateo functions as

the HMO for Medi-Cal, Healthy Kids and HealthWorx. Another example for a popular HMO is Kaiser Permanente which maintains its own facilities and can, therefore, keep administrative overhead costs down while passing on the cost savings to the consumer by offering lower premiums, or plans that allow access to better specialty care.

Preferred Provider Organization (PPO)

A preferred provider organization (PPO) is a type of health insurance arrangement that allows plan participants relative freedom to choose the doctors and hospitals they want to visit. Obtaining services from doctors within the health insurance plan's network, called "preferred providers", results in lower fees for policyholders; however, out-of-network doctors are still covered. Coverage under a preferred provider organization (PPO) requires ongoing payment of premiums by policyholders to the insurance company. Blue Shield of CA and Anthem Blue Cross are the biggest PPO carriers in California.