Health Insurance Glossary

Definitions of common health insurance industry terms. A glossary or dictionary to help consumers with health insurance vocabulary.

A

Actuary: A mathematician working for a health insurance company responsible for determining what premiums the company needs to charge based in large part on claims paid verses amounts of premium generated. Their job is to make sure a block of business is priced to be profitable.

Agent: Licensed salespersons who represent one or more health insurance companies and presents their products to consumers.

Association: A group. Often, associations can offer individual health insurance plans specially designed for their members.

B

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

Brand-name drug: Prescription drugs marketed with a specific brand name by the company that manufactures it, usually the company which develops and patents it. When patents run out, generic versions of many popular drugs are marketed at lower cost by other companies. Check your insurance plan to see if coverage differs between name-brand and their generic twins.

Broker: Licensed insurance salesperson who obtains quotes and plan from multiple sources information for clients.

C

Carrier: The insurance company or HMO offering a health plan.

Certificate of Insurance: The printed description of the benefits and coverage provisions forming the contract between the carrier and the customer. Discloses what it covered, what is not, and dollar limits.

Claim: A request by an individual (or his or her provider) to an individual's insurance company for the insurance company to pay for services obtained from a health care professional.

Co-Insurance: Co-insurance refers to money that an individual is required to pay for services, after a deductible has been paid. In some health care plans, co-insurance is called "co-payment." Co-insurance is often specified by a percentage. For example, the employee pays 20 percent toward the charges for a service and the employer or insurance company pays 80 percent.

Co-Payment: Co-payment is a predetermined (flat) fee that an individual pays for health care services, in addition to what the insurance covers. For example, some HMOs require a $10 "co-payment" for each office visit, regardless of the type or level of services provided during the visit. Co-payments are not usually specified by percentages.

COBRA: Federal legislation that lets you, if you work for an insured employer group of 20 or more employees, continue to purchase health insurance for up to 18 months if you lose your job or your coverage is otherwise terminated. For more information, visit the Department of Labor.

D

Deductible: The amount an individual must pay for health care expenses before insurance (or a self-insured company) covers the costs. Often, insurance plans are based on yearly deductible amounts.

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

Dependents: Spouse and/or unmarried children (whether natural, adopted or step) of an insured.

E

Effective Date: The date your insurance is to actually begin. You are not covered until the policies effective date.

Exclusions: Medical services that are not covered by an individual's insurance policy.

Explanation of Benefits: The insurance company's written explanation to a claim, showing what they paid and what the client must pay. Sometimes accompanied by a benefits check.

G

Generic Drug: A "twin" to a "brand name drug" once the brand name company's patent has run out and other drug companies are allowed to sell a duplicate of the original. Generic drugs are cheaper, and most prescription and health plans reward clients for choosing generics.

Group Insurance: Coverage through an employer or other entity that covers all individuals in the group.

H

Health Savings Account (HSA): An HSA is a tax-advantaged savings account that allows individuals to pay current health care costs or save for anticipated future expenses. To be eligible, an individual must be covered by a high-deductible health plan and not be eligible for coverage under any other health plan. Contributions to the HSA can be made by the employer, the employee or both. Contributions are tax deductible and earn interest tax free. The accounts are portable, meaning you can take them with you when you leave your employer. And balances accumulate from year to year. HSA funds can be used to pay for qualified medical expenses or withdrawn in cash, although cash withdrawals become taxable and may be subject to an additional withdrawal penalty.

Health Maintenance Organizations (HMOs): Health Maintenance Organizations represent "pre-paid" or "captivated" 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.)

HIPAA: A Federal law passed in 1996 that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also creates the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care. Full name is "The Health Insurance Portability and Accountability Act of 1996."

I

In-network: Providers or health care facilities which are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.

Independent Practice Associations: IPAs are similar to HMOs, except that individuals receive care in a physician's own office, rather than in an HMO facility.

Individual Health Insurance: Health insurance coverage on an individual, not group, basis. The premium is usually lower for an individual health insurance plan than for a group policy, but you may not qualify for a individual plan.

L

Lifetime Maximum Benefit (or Maximum Lifetime Benefit): the maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

Limitations: a limit on the amount of benefits paid out for a particular covered expense, as disclosed on the Certificate of Insurance.

LOS: LOS refers to the length of stay. It is a term used by insurance companies, case managers and/or employers to describe the amount of time an individual stays in a hospital or in-patient facility.

M

Managed Care: A medical delivery system that attempts to manage the quality and cost of medical services that individuals receive. Most managed care systems offer HMOs and PPOs that individuals are encouraged to use for their health care services. Some managed care plans attempt to improve health quality, by emphasizing prevention of disease.

Maximum Dollar Limit: The maximum amount of money that an insurance company (or self-insured company) will pay for claims within a specific time period. Maximum dollar limits vary greatly. They may be based on or specified in terms of types of illnesses or types of services. Sometimes they are specified in terms of lifetime, sometimes for a year.

Medigap Insurance Policies: Medigap insurance is offered by private insurance companies, not the government. It is not the same as Medicare or Medicaid. These policies are designed to pay for some of the costs that Medicare does not cover.

Multiple Employer Trust (MET): A trust consisting of multiple small employers in the same industry, formed for the purpose of purchasing group health insurance or establishing a self-funded plan at a lower cost than would be available to each of the employers individually.

N

Network: A group of doctors, hospitals and other health care providers contracted to provide services to insurance companies customers for less than their usual fees. Provider networks can cover a large geographic market or a wide range of health care services. Insured individuals typically pay less for using a network provider.

O

Open-ended HMOs: HMOs which allow enrolled individuals to use out-of-plan providers and still receive partial or full coverage and payment for the professional's services under a traditional indemnity plan.

Out-of-Plan (Out-of-Network): This phrase usually refers to physicians, hospitals or other health care 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 covered only in part by an individual's insurance company.

Out-Of-Pocket Maximum: A predetermined limited amount of money that an individual must pay out of their own savings, before an insurance company or (self-insured employer) will pay 100 percent for an individual's health care expenses.

Outpatient: An individual (patient) who receives health care services (such as surgery) on an outpatient basis, meaning they do not stay overnight in a hospital or inpatient facility. Many insurance companies have identified a list of tests and procedures (including surgery) that will not be covered (paid for) unless they are performed on an outpatient basis. The term outpatient is also used synonymously with ambulatory to describe health care facilities where procedures are performed.

P

Plan Administration: Supervising the details and routine activities of installing and running a health plan, such as answering questions, enrolling individuals, billing and collecting premiums, and similar duties.

Pre-Admission Certification: Also called pre-certification review, or pre-admission review. Approval by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or in-patient facility, granted prior to the admittance. Pre-admission certification often must be obtained by the individual. Sometimes, however, physicians will contact the appropriate individual. The goal of pre-admission certification is to ensure that individuals are not exposed to inappropriate health care services (services that are medically unnecessary).

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

Pre-existing Conditions: A medical condition that is excluded from coverage by an insurance company, because the condition was believed to exist prior to the individual obtaining a policy from the particular insurance company.

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

Preferred Provider Organizations (PPOs): You or your employer receive discounted rates if you use doctors from a pre-selected group. If you use a physician outside the PPO plan, you must pay more for the medical care.

Primary Care Provider (PCP): A health care professional (usually a physician) who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a "quarterback" for an individual's medical care, referring the individual to more specialized physicians for specialist care.

Provider: Provider is a term used for health professionals who provide health care services. Sometimes, the term refers only to physicians. Often, however, the term also refers to other health care professionals such as hospitals, nurse practitioners, chiropractors, physical therapists, and others offering specialized health care services.

R

Reasonable and Customary Fees: The average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the amount of money they will approve for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference. Sometimes, however, if an individual questions his or her physician about the fee, the provider will reduce the charge to the amount that the insurance company has defined as reasonable and customary.

Rider: A modification made to a Certificate of Insurance regarding the clauses and provisions of a policy (usually adding or excluding coverage).

S

Second Opinion: It is a medical opinion provided by a second physician or medical expert, when one physician provides a diagnosis or recommends surgery to an individual. Individuals are encouraged to obtain second opinions whenever a physician recommends surgery or presents an individual with a serious medical diagnosis.

Second Surgical Opinion: These are now standard benefits in many health insurance plans. It is an opinion provided by a second physician, when one physician recommends surgery to an individual.

Short-Term Medical: Temporary coverage for an individual for a short period of time, usually from 30 days to six months.

Small Employer Group: Generally means groups with 1 99 employees. The definition may vary between states.

State Mandated Benefits: When a state passes laws requiring that health insurance plans include specific benefits.

Stop-loss: The dollar amount of claims filed for eligible expenses at which point you've paid 100 percent of your out-of-pocket and the insurance begins to pay at 100%. Stop-loss is reached when an insured individual has paid the deductible and reached the out-of-pocket maximum amount of co-insurance.

T

Triple-Option: Insurance plans that offer three options from which an individual may choose. Usually, the three options are traditional indemnity, an HMO, and a PPO.

U

Underwriter: The company that assumes responsibility for the risk, issues insurance policies and receives premiums.

Usual, Customary and Reasonable (UCR) or Covered Expenses: An amount customarily charged for or covered for similar services and supplies which are medically necessary, recommended by a doctor, or required for treatment.

W

Waiting Period: A period of time when you are not covered by insurance for a particular problem.