Access
The availability of medical care. The quality of one's access to medical care is determined by location, transportation options, and the type of medical care facilities available in the area, etc..

Accident
For health insurance purposes, an accident is an unforeseen, unexpected and unintended event resulting in bodily injury.

Accumulation Period
The period of time during which an insured person incurs eligible medical expenses toward the satisfaction of a deductible.

Actively-at-work
Most group health insurance policies state that if an employee is not "actively-at-work" on the day the policy goes into effect, the coverage will not begin until the employee returns to work.

Actual Charge
The actual dollar amount charged by a physician or other provider for medical services rendered, as distinguished from the allowable charge.

Actuary
A person professionally trained in the mathematical and statistical aspects of the insurance industry.
Actuaries frequently calculate premium rates, reserves and dividends and assist in estimating the costs and savings of benefit changes.

Acupuncture
Typically, acupuncture services include services performed by a licensed acupuncturist.

Acute Care
Medical care administered, frequently in a hospital or by nursing professionals, for the treatment of a serious injury or illness or during recovery from surgery. Medical conditions requiring acute care are typically periodic or temporary in nature, rather than chronic.

Administrative Services Only (ASO) Agreement
A business contract under which an insurance company agrees to perform specific administrative duties for the maintenance of a self-funded health insurance plan.

Admissions/1,000
A statistic used by health insurance companies describing the number of hospital admissions for each 1000 persons covered under a health insurance plan within a given time period.

Admits
Hospital admissions. A term used to describe the number of persons admitted to a hospital within a given period.

Adverse Selection
The tendency of those who experience greater health risks to apply for and continue their coverage under any given health insurance plan. When adverse selection increases, health insurance companies experience greater expenses and may raise rates.

Age Change
For insurance purposes, this is the date on which a person's age changes. Note that this may not correspond with the individual's actual birthday, but may fall midway between birthdays. An age change may result in an increase in rates.

Age Limits
Ages below and above which an insurance company will not accept applications or renew policies.

Age/Sex Factor
A factor employed by insurance companies in the underwriting process, used to determine a group's risk of incurring medical costs, based on the ages and genders of the persons in that group.

Agent
A state-licensed individual or entity representing one or more insurance companies. An agent solicits and facilitates the sale of insurance contracts or policies and provides services to the policyholder on behalf of the insurer. See also, Broker.

Allied Health Personnel
Also referred to as paramedical personnel, these are health workers (often licensed) who perform duties that would otherwise be performed by physicians, optometrists, dentists, podiatrists, nurses and chiropractors.

Allowable Charge
-also referred to as the Allowed Amount, Approved Charge or Maximum Allowable. See also, Usual, Customary and Reasonable Charge. This is the dollar amount typically considered payment-in-full by an insurance company and an associated network of healthcare providers. The Allowable Charge is typically a discounted rate rather than the actual charge. It may be helpful to consider an example: You have just visited your doctor for an earache. The total charge for the visit comes to $100. If the doctor is a member of your health insurance company's network of providers, he or she may be required to accept $80 as payment in full for the visit - this is the Allowable Charge. Your health insurance company will pay all or a portion of the remaining $80, minus any co-payment or deductible that you may owe. The remaining $20 is considered provider write-off. You cannot be billed for this provider write-off. If, however, the doctor you visit is not a network provider then you may be held responsible for everything that your health insurance company will not pay, up to the full charge of $100.

This term may also be used within a Medicare context to refer to the amount that Medicare considers payment in full for a particular, approved medical service or supply.

Allowable Costs
Charges for healthcare services and supplies for which benefits are available under your health insurance plan.

Allowed Amount
-see Allowable Charge.

Alternate Delivery System
Healthcare services or facilities which "deliver" care that is more cost-effective than that provided in a hospital. Alternate Delivery Systems may include skilled nursing facilities, hospice programs and home health care services.

Alternative Medicine
Any medical practice of form of treatment not generally recognized as effective by the medical community at large. Alternative medicine may encompass a broad range of services and practices including acupuncture, homeopathy, aromatherapy, naturopathy, etc.. Many insurance companies do not provide coverage for these services.

Ambulatory Care
Medical care rendered on an outpatient basis and which may include diagnosis, certain forms of treatment, surgery and rehabilitation. See also, Ambulatory Setting.

Ambulatory Setting
Medical facilities such as surgery centers, clinics and offices in which healthcare is provided on an outpatient basis.

Ancillary Fee
An extra fee sometimes associated with obtaining prescription drugs which are not listed on a health insurance plan's formulary of covered medications.

Ancillary Products
Additional health insurance products (such as vision or dental insurance) that may be added to a medical insurance plan for an additional fee.

Ancillary Services
Supplemental healthcare services such as laboratory work, x-rays or physical therapy that are provided in conjunction with medical or hospital care.

Application Fee
The health insurance company may require a one-time application fee. Some insurance companies may refund this fee if the application is not approved. See More Insurance Plan Details section for additional information.

Approved Charge
-see Allowable Charge.

Approved Health Care Facility or Program
A medical facility or healthcare program (often organized through a hospital or clinic) that has been approved by a health insurance plan to provide specific services for specific conditions.

Assignment of Benefits
The payment of health insurance benefits to a healthcare provider rather than directly to the member of a health insurance plan.

Attending Physician Statement (APS)
A physician's assessment of a patient's state of health as outlined in office notes and test results compiled by the physician. An APS may be requested by an insurance company in lieu of a medical examination in order to determine the state of a health insurance applicant's health for underwriting purposes.

Balance Billing
The amount you could be responsible for (in addition to any co-payments, deductibles or coinsurance) if you use an out-of-network provider and the fee for a particular service exceeds the allowable charge for that service.

Basic Hospital Expense Insurance
-see Hospitalization Insurance.

Bed Days/1,000
A statistic used by health insurance companies describing the number of inpatient hospital days for each 1000 persons covered under a health insurance plan within a given time period.

Benefit
A general term referring to any service (such as an office visit, laboratory test, surgical procedure, etc.) or supply (such as prescription drugs, durable medical equipment, etc.) covered by a health insurance plan in the normal course of a patient's healthcare.

Benefit Level
The maximum amount a health insurance company agrees to pay for a specific covered benefit.

Benefit Package
A description of the healthcare services and supplies that a health insurance company covers for members of a specific health insurance plan.

Benefit Riders
This term may be used to describe ancillary products purchased in conjunction with a medical insurance plan.

Benefit Year
The annual cycle in which a health insurance plan operates. At the beginning of your benefit year, the health insurance company may alter plan benefits and update rates. Some benefit years follow the calendar year, renewing in January, whereas others may renew in late summer or fall.

Binding Receipt
When you submit an application for health insurance and include an initial payment, the health insurance company may provide you with a binding receipt. A binding receipt indicates that, if coverage is approved, the health insurance company is required to initiate coverage from the date on which payment was received.

Birthday Rule
One method used by health insurance companies to determine which parent's health insurance coverage will be primary for a dependent child, when both parents have separate coverage. Typically, the health insurance plan of the parent whose birthday falls earliest in the year will be considered primary. For more information, see also, COB.

Board-certified
A board-certified physician is one that has successfully completed an educational program and evaluation process approved by the American Board of Medical Specialties, including an examination designed to assess the knowledge, skills and experience required to provide quality patient care in a specific specialty.

Broker
Though sometimes used in a sense synonymous with the term agent, a broker typically works to match applicants with a health insurance company or plan best matched to their needs. The broker is paid a commission by the insurance company, but represents the applicant rather than the insurance company itself.

Business License
A license from a governmental agency authorizing an individual or an employer to conduct business.

Business Structure
A state-designated legal structure that governs business taxes, liability, and operational requirements. Examples include: sole proprietorship, partnership, corporation, or LLC.

COB (Coordination of Benefits)
This is the process by which a health insurance company determines if it should be the primary or secondary payer of medical claims for a patient who has coverage from more than one health insurance policy. See also, Non-duplication of Benefits.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)
Federal legislation allowing an employee or an employee's dependents to maintain group health insurance coverage through an employer's health insurance plan, at the individual's expense, for up to 18 months in certain circumstances. COBRA coverage may be extended beyond 18 months in certain circumstances. COBRA rules typically apply when an employee loses coverage through loss of employment (except in cases of gross misconduct) or due to a reduction in work hours. COBRA benefits also extend to spouses or other dependents in case of divorce or the death of the employee. Children who are born to, adopted, or placed for adoption with the covered employee while he or she is on COBRA coverage are also entitled to coverage. All companies that have averaged at least 20 full-time employees over the past calendar year must comply with COBRA regulations.

Capitation
A method of compensation sometimes employed by health insurance companies, in which payment is made to a healthcare provider on a per-patient rather than a per-service basis. For example, under capitation an HMO doctor may be paid a fixed amount each month to serve as the primary care physician for a specific number of HMO members assigned to his or her care, regardless of how little or how much care each member needs.

Carrier
Any insurer, managed care organization, or group hospital plan, as defined by applicable state law.

Carry-over Provision
A provision of some health insurance plans allowing medical expenses paid for by the member in the last three months of the year to be carried over and applied toward the next year's deductible.

Case Management
When a member requires a great deal of medical care, the health insurance company may assign the member to case management. A case manager will work with the patient's healthcare providers to assist in the management of the patient's long-term needs, with appropriate recommendations for care, monitoring and follow-up. A case manager will also help ensure that the member's health insurance benefits are being properly and fully utilized and that non-covered services are avoided when possible.

Centers for Medicare and Medicaid Services
Formerly known as the Health Care Financing Administration, the Centers for Medicare and Medicaid Services (CMS) is part of the federal government's Department of Health and Human Services, and is responsible for the administration of the Medicare and Medicaid programs. The CMS establishes standards for healthcare providers that must be complied with in order for providers to meet certain certification requirements.

Certificate of Coverage
A document given to an insured that describes the benefits, limitations and exclusions of coverage provided by an insurance company.

Chemical Dependency Inpatient
Typically, chemical dependency inpatient services include services relating to the treatment of a chemical dependency that requires a stay at a hospital or other medical facility.

Chiropractic
Typically, chiropractic services include services provided by a licensed chiropractor.

Chronic
In healthcare and insurance terminology, a chronic condition is one that is permanent, recurring or long lasting, as opposed to an acute condition.

Claim
A bill for medical services rendered, typically submitted to the insurance company by a healthcare provider.

Coinsurance
The amount that you are obliged to pay for covered medical services after you've satisfied any co-payment or deductible required by your health insurance plan. Coinsurance is typically expressed as a percentage of the charge or allowable charge for a service rendered by a healthcare provider. For example, if your insurance company covers 80% of the allowable charge for a specific service, you may be required to cover the remaining 20% as coinsurance.

Company
The insurance company that is offering this health insurance plan.

Co-payment
A specific charge that your health insurance plan may require that you pay for a specific medical service or supply, also referred to as a "co-pay." For example, your health insurance plan may require a $15 co-payment for an office visit or brand-name prescription drug, after which the insurance company often pays the remainder of the charges.

Date of Service
The date on which a healthcare service was provided.

Deductible
A specific dollar amount that your health insurance company may require that you pay out-of-pocket each year before your health insurance plan begins to make payments for claims. Not all health insurance plans require a deductible. As a general rule (though there are many exceptions), HMO plans typically do not require a deductible, while most Indemnity and PPO plans do.

Deductible Carry-over Credit
-see, Carry-over Provision

Department of Health and Human Services
A department of the federal government responsible for certain social service functions, such as the administration and supervision of the Medicare program.

Dependent Coverage
Health insurance coverage extended to the spouse and unmarried children of the primary insured member. Certain age restrictions on the coverage of children may apply.

Designated Mental Health Provider
An organization hired by a health insurance plan to provide mental health and/or substance abuse treatment services.

Drug Formulary
A list of prescription medications selected for coverage under a health insurance plan. Drugs may be included on a drug formulary based upon their efficacy, safety and cost-effectiveness. Some health insurance plans may require that patients obtain preauthorization before non-formulary drugs are covered. Other health insurance plans may require that a patient pay a greater share or all of the cost involved in obtaining a non-formulary prescription.

Drug Maintenance List
A list of commonly prescribed drugs intended for patients' ongoing or long-term use.

Drug Utilization Review (DUR)
The process by which health insurance companies evaluate or review the use of prescription drugs for appropriateness in the treatment of a patient.

Durable Medical Equipment (DME)
Medical equipment used in the course of treatment or home care, including such items as crutches, knee braces, wheelchairs, hospital beds, prostheses, etc.. Coverage levels for DME often differ from coverage levels for office visits and other medical services.

ERISA (Employment Retiree Income Security Act of 1974)
Federal legislation designed to protect the rights of retirees and beneficiaries of benefit plans offered by employers.

Effective Date
The date on which health insurance coverage comes into effect.

Eligibility Date
The date on which a person becomes eligible for insurance benefits.

Eligibility Requirements
Conditions that must be met in order for an individual or group to be considered eligible for insurance coverage.

Eligible Dependent
A dependent (usually spouse or child) of an insured person who is eligible for insurance coverage.

Eligible Employee
An employee who is eligible for insurance coverage based upon the stipulations of the group health insurance plan.

Eligible Expenses
Expenses defined by the health insurance plan as eligible for coverage.

Eligible Person
This term is used to designate a person who is eligible for insurance coverage even though he or she may not be an employee, but rather a member of an organization or union.

Emergency Room
Typically, emergency room services include all services provided when a patient visits an emergency room for an emergency condition. An emergency condition is any medical condition of recent onset and severity, including but not limited to severe pain, that would lead to a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organ or part.

Employee Certificate of Insurance
-see Certificate of Coverage.

Employee Contribution
The portion of the health insurance premium paid for by the employee, usually deducted from wages by the employer.

Employer Contribution
The portion of an employee's health insurance premium paid for by the employer.

Employer Wage and Tax Statement
An employer tax reporting statement submitted to the applicable governmental agency to establish and report the employer's tax responsibilities.

Enrollee
An eligible person or eligible employee who is enrolled in a health insurance plan. Dependents are not referred to as enrollees.

Enrollment
The process through which an approved applicant is signed up with the health insurance company and coverage is made effective. This term may also be used to describe the total number of enrollees in a health insurance plan.

Enrollment Period
The period of time during which an eligible employee or eligible person may sign up for a group health insurance plan.

EPO(Exclusive Provider Organization)
An EPO is a Exclusive Provider Organization. As a member of an EPO, you can use the doctors and hospitals within the EPO network, but cannot go outside of the network for care. There are no out-of-network benefits.

Estimated Cost
The amount quoted is an estimated cost of the health plan, which is subject to change based on your medical history, the underwriting practices of the health plan, the optional benefits you selected, if any, and other relevant factors. It may be the sum of estimated premiums and other recurring charges, if the insurance company has such charges.

Evidence of Coverage
-see Certificate of Coverage.

Evidence of Insurability
When applying for an individual health insurance plan, an applicant may be asked to confirm his or her health condition in writing, through a questionnaire or through a medical examination. When applying for group health insurance, evidence of insurability is only required in specific cases (for instance, when a person fails to enroll in the group plan during the enrollment period).

Examination
In health insurance usage, this generally refers to a medical examination performed as part of an application for a life or health insurance plan. See, Evidence of Insurability.

Exclusions
Specific conditions, services or treatments for which a health insurance plan will not provide coverage.

Experimental or Investigational Procedures
Any healthcare services, supplies, procedures, therapies or devices the effectiveness of which a health insurance company considers unproven. These services are generally excluded from coverage.

Explanation of Benefits (EOB)
A statement sent from the health insurance company to a member listing services that were billed by a healthcare provider, how those charges were processed, and the total amount of patient responsibility for the claim.

Extended Coverage
A provision of some health insurance plans allowing for coverage of certain healthcare services after the member is no longer covered on the plan. For example, a member's maternity benefits may be extended beyond the expected end of coverage if the woman was already receiving covered maternity services.

Extension of Benefits
A provision of some health insurance plans allowing for coverage to be extended beyond a scheduled termination date. The extended coverage is made available only when the member is disabled or hospitalized as of the intended termination date, and continues only until the patient leaves the hospital or returns to work.

Fee-For-Service Plan
-see Indemnity Plan.

Fictitious Business Name Statement
A certificate provided by a local or state governmental office that clarifies the true owner of a business or company. When a company or individual conducts business under an assumed name, this is referred to as a "fictitious name." It may also be referred to as a "trade name" or "doing-business-as (DBA)" name. For the purposes of group health insurance, this statement confirms the identity of the business applying for coverage with a health insurance company.

Formulary
-see Drug Formulary.

Gatekeeper
A term used to describe the role of the primary care physician in an HMO plan. In an HMO plan, primary care physicians serves as the patient's main point of contact for healthcare services and refer patients to specialists for specific needs.

Generic Drug
A drug which is exactly the same as a brand name prescription drug, but which can be produced by other manufacturers after the brand name drug's patent has expired. Generic drugs are usually less expensive than brand name drugs.

Grace Period
A time period after the payment due date, during which insurance coverage remains in force and the policyholder may make a payment without penalty.

Grievance Procedure
The procedure by which a member or healthcare provider is allowed to file a complaint with a health insurance company and seek a remedy.

Group
A number of individuals covered under a single health insurance contract, usually a group of employees.

Group Health Insurance
A health insurance plan that provides benefits for employees of a business or members of an organization, as opposed to individual and family health insurance.

Guaranteed Issue
A term used to describe insurance coverage that must be issued regardless of health status. In most states, group health insurance plans are often described as guaranteed issue plans, because a health insurance company generally cannot refuse coverage to a qualifying business or organization based on the health status of their employees or members. In some states, all health insurance plans are guaranteed issue.

Guaranteed Renewable Contract
A contract under which the insured person has the right (usually up to a certain age) to renew and continue his or her health insurance policy by the timely payment of premiums.

HIPAA (Health Insurance Portability and Accountability Act of 1996)
Legislation mandating specific privacy rules and practices for medical care providers and health insurance companies, designed to streamline the healthcare and insurance industries and to protect the privacy and identity of healthcare consumers. HIPAA also provides additional protections for consumers, designed to help them obtain or retain health insurance coverage in certain circumstances. For more information on HIPAA rules and regulations, visit the Centers for Medicare and Medicaid Services website at http://www.cms.hhs.gov.

HMO
HMO means "Health Maintenance Organization." HMO plans offer a wide range of health care services through a network of providers that contract exclusively with the HMO, or who agree to provide services to members at a pre-negotiated rate. As a member of an HMO, you will need to choose a primary care physician ("PCP") who will provide most of your health care and refer you to HMO specialists as needed. Some HMO plans require that you fulfill a deductible before services are covered. Others only require you to make a copayment when services are rendered. Health care services obtained outside of the HMO are typically not covered, though there may be exceptions in the case of an emergency.
An HMO may be right for you if:

- You're willing to play by the rules and coordinate your care through a primary care physician
- You're looking for comprehensive benefits at a reasonable monthly premium
- You value preventive care services: coverage for checkups, immunizations and similar services are often emphasized by HMOs

HSA (Health Savings Account)
A tax advantaged savings account to be used in conjunction with certain high-deductible (low premium) health insurance plans to pay for qualifying medical expenses. Contributions may be made to the account on a tax-free basis. Funds remain in the account from year to year and may be invested at the discretion of the individual owning the account. Interest or investment returns accrue tax-free. Penalties may apply when funds are withdrawn to pay for anything other than qualifying medical expenses.

Health Care Financing Administration (HCFA)
See the Centers for Medicare and Medicaid Services.

Health Service Agreement
An agreement between an employer and a health insurance company outlining benefits, enrollment procedures, eligibility standards, etc.

Home Health Agency
A certified healthcare agency that provides home health care services. See, Home Health Care.

Home Health Care
Part-time care that is provided by medical professionals in the home setting rather than in a hospital or skilled nursing facility.

Hospice Care
Care rendered either on an inpatient basis or in the home setting for a terminally ill patient. Often referred to as "palliative" or "supportive" care, hospice care emphasizes the management of pain and discomfort and the emotional support of the patient and family. See also, Respite Care.

Hospital Benefits
Benefits payable for hospital room and board and other miscellaneous charges resulting from hospitalization.

Hospitalization
Typically, hospitalization services include services related to staying at a hospital for either scheduled procedures, accidents or medical emergencies. Hospitalization services typically do not include hospital stays for giving birth to a child.

Hospitalization Insurance
Insurance intended to provide coverage in case of hospitalization, including benefits for room and board and miscellaneous expenses, within certain limitations.

IPA (Individual Practice Association)
An organization of physicians who may maintain separate offices but who negotiate contracts with insurance companies and medical facilities as a group. Some health insurance applications will ask you to provide your primary care physician's IPA number. It can usually be found in the health insurance plan's online directory.

In-area Services
Healthcare services rendered within a health insurance plan's coverage area.

Incontestable Clause
A provision in an insurance policy that states that the validity of the insurance contract cannot be contested after two (or sometimes three) years.

Indemnity Plan
Also called "fee-for-service" plans, Indemnity plans typically allow you to direct your own health care and visit whatever doctors or hospitals you like. The insurance company then pays a set portion of your total charges. You may be required to pay for some services up front and then apply to the insurance company for reimbursement. Indemnity plans typically require that you fulfill an annual deductible. Because of the freedom they allow members, Indemnity plans are sometimes more expensive than other types of plans.

An Indemnity plan may be right for you if:

- You want the greatest level of freedom possible in choosing which doctors or hospitals to visit
- You don't mind coordinating the billing and reimbursement of your claims yourself

Individual and Family Health Insurance
A type of health insurance purchased by an individual or family, independent of any employer group or organization. In most states, a health insurance company may decline coverage for an individual or family health insurance plan based on the medical conditions or health histories of the applicants or dependents.

Infertility
Typically, infertility services include any medical services, both inpatient and outpatient, to assist with the conception of child.

Inpatient
A term used to describe a person admitted to a hospital for at least 24 hours. It may also be used to describe the care rendered in a hospital when the duration of the stay is at least 24 hours.

Integrated Delivery System
A group of doctors, hospitals and other providers who work together to deliver a broad range of healthcare services.

Intermediate Care
A level of nursing care, considered less intensive than skilled nursing care, but which may be rendered in a skilled nursing or intermediate care facility.

Lab/X-Ray
Typically, lab/x-ray is any diagnostic lab test or diagnostic/therapeutic x-ray performed in support of basic health services. Lab services typically include services like blood panels and urinalysis. X-ray services typically include basic outpatient skeletal or other plain film x-ray, outpatient ultrasound, GI series, MRI, and CT scan. Prostate cancer screening, mammograms, and pap smears may be covered by Lab/X-Ray benefit, or they may be covered by Periodic OB-GYN benefit or Preventative Care benefits. Typically, dental x-rays are not included in Lab/X-ray benefits.

Lapse
The termination of insurance coverage due to lack of payment after a specific period of time.

Length of Stay (LOS)
The total number of days that a patient stays in a facility such as a hospital.

Lifetime Maximum
The maximum dollar amount that a health insurance company agrees to pay on behalf of a member for covered services during the course of his or her lifetime.

Limitations
A term referring to any maximums that a health insurance plan imposes on specific benefits.

Long-term Care
Care provided on a continuing basis for the chronically ill or disabled. Long-term care may be provided on an inpatient basis (at a long-term care facility) or in the home setting.

MSA (Medical Savings Account)
A tax-advantaged personal savings account used in conjunction with a high-deductible health insurance plan. MSAs are currently being phrased out and replaced with HSAs. See HSA.

Major Medical Insurance
A type of medical insurance plan that provides benefits for a broad range of healthcare services, both inpatient and outpatient. Major medical insurance plans often carry a high deductible.

Managed Care
A general term used to describe a variety of healthcare and health insurance systems that attempt to guide a member's use of benefits, typically by requiring that a member coordinate his or her healthcare through a primary care physician, or by encouraging the use of a specific network of healthcare providers. The management of healthcare is intended to keep costs -and monthly premiums- as low as possible. There are several different types of managed care health insurance plans, including HMO, PPO, and POS plans

Maternity (Inpatient)
Typically, inpatient maternity services include hospitalization and physician fees associated with the birth of a child.

Maternity (Outpatient)
Typically, outpatient maternity services include OB-GYN office visits during pregnancy and immediately after giving birth.

Maternity Coverage
Maternity coverage means the insurance covers part or all of the medical cost during a woman's pregnancy. Coverage is broken down into inpatient and outpatient services. Typically, inpatient coverage includes hospitalization and physician fees associated with child birth. Outpatient coverage pays for prenatal and postnatal OB-GYN office visits.

Maximum Allowable
see Allowable Charge.

Max Duration
Maximum duration is the longest coverage period offered by the plan.

You should choose a plan which has a coverage period which will safely cover your insurance needs while you are waiting for a standard long-term policy to begin. You should apply for short-term coverage only if you know with certainty that you will have standard, long-term coverage (or coverage through an employer) at a future date.

Maximum Out-Of-Pocket Costs
The most a member will be required to pay out-of-pocket in a benefit year, often including co-payments coinsurance and deductibles.

Medicaid
A state-funded healthcare program for low income and disabled persons.

Medical Necessity
A basic criterion used by health insurance companies to determine if healthcare services should be covered. A medical service is generally considered to meet the criteria of medical necessity when it is considered appropriate, consistent with general standards of medical care, consistent with a patient's diagnosis, and is the least expensive option available to provide a desired health outcome. Of course, preventive care services that may be covered under a health insurance plan are not always subject to the criteria of medical necessity.

Medicare
A national, federally-administered health insurance program authorized in 1965 to cover the cost of hospitalization, medical care, and some related health services for most people over age 65 and certain other eligible individuals.

Medicare Beneficiary
Anyone entitled to Medicare benefits based on the rules for eligibility outlined by the Social Security Administration.

Medicare Supplement Insurance
Health insurance provided to an individual or group that is intended to help fill in the gaps in the coverage provided by Medicare.

Member
Anyone covered under a health insurance plan, an enrollee or eligible dependent.

Mental Health Inpatient
Typically, mental health inpatient refers to services rendered when a patient stays at a hospital or other medical facility for treatment of a mental health condition.

Mental Health Office Visits
Typically, mental health office visits include visits to a licensed medical provider for treatment of a mental health condition.

National Association of Insurance Commissioners (NAIC)
The NAIC is a national association of state officials charged with regulating insurance. The NAIC was formed to help provide some measure of national uniformity in insurance regulation.

National Drug Code (NDC)
A system employed by healthcare providers and insurance companies for classifying and identifying drugs. Each prescription drug in common use is assigned an NDC number.

Network
A "Network" plan is a variation on a PPO plan. With a Network plan you'll need to get your medical care from doctors or hospitals in the insurance company's network if you want your claims paid at the highest level. You will probably not be required to coordinate your care through a single primary care physician, as you would with an HMO, but it's up to you to make sure that the health care providers you visit participate in the network. Services rendered by out of network providers may not be covered or may be paid at a lower level.

A Network plan may be right for you if:

- Your favorite doctor already participates in the network (use our Doctor Finder tool to find out)
- You want some freedom to direct your own health care but don't mind working within a network of preferred providers

Network Provider
A healthcare provider who has a contractual relationship with a health insurance company. Among other things, this contractual relationship may establish standards of care, clinical protocols, and allowable charges for specific services. In return for entering into this kind of relationship with an insurance company, a healthcare provider typically gains in numbers of patients and a primary care physician may receive a capitation fee for each patient assigned to his or her care.

Non-duplication of Benefits
-see, COB.

Nursing Home
A licensed facility which provides general nursing care to those who are chronically ill or who require constant supervision and assistance with the needs of daily living.

Office Visit

An office visit is the amount you pay when you see the doctor or dentist for routine care.

- Examples for $100 office visit:
- If the plan's office visit is $25, then you pay $25.
- If the plan's office visit is 30% before deductible, then you pay $30.
- If the plan's office visit is 35% after deductible, then, if you have not yet reached your deductible, you pay $100; if you have reached your deductible you pay $35.

Select higher amounts to lower your monthly premiums.

Office Visit (IFP)
Typically, an office visit is an outpatient visit to a physician's office for illness or injury.

Open Enrollment Period
A time period during which eligible persons or eligible employees may opt to sign up for coverage under a group health insurance plan. During an open enrollment period, applicants typically will not be required to provide evidence of insurability.

Out-of-network Care
Healthcare rendered to a patient outside of the health insurance company's network of preferred providers. In many cases, the health insurance company will not pay for these services.

Out-of-pocket Costs
Healthcare costs that a patient or enrollee must pay for out of his or her own pocket, often including such costs as coinsurance, deductibles, etc..

Out-of-Pocket Maximum
-see Maximum Out-of-pocket Costs.

Outpatient
A term referring to a patient who receives care at a medical facility but who is not admitted to the facility overnight, or for 24 hours or less. The term may also refer to the healthcare services that such a patient receives.

Outpatient Surgery
Typically, outpatient surgery is defined as any surgical procedure that does not require an overnight stay in a hospital.

Over-the-counter (OTC) Drugs
Drugs that may be obtained without a prescription.

POS
POS stands for "Point of Service." POS plans combine elements of both HMO and PPO plans. As a member of a POS plan, you may be required to choose a primary care physician who will then make referrals to specialists in the health insurance company's network of preferred providers. Care rendered by non-network providers will typically cost you more out of pocket, and may not be covered at all.

A POS plan may be right for you if:

- You're willing to play by the rules and possibly coordinate your care through a primary care physician
- Your favorite doctor already participates in the network (use our Doctor Finder tool to find out)

PPO
PPO means "Preferred Provider Organization." Like the name implies, with a PPO plan you'll need to get your medical care from doctors or hospitals on the insurance company's list of preferred providers if you want your claims paid at the highest level. You will probably not be required to coordinate your care through a single primary care physician, as you would with an HMO, but it's up to you to make sure that the health care providers you visit participate in the PPO. Services rendered by out of network providers may not be covered or may be paid at a lower level. A broad variety of PPO plans are available, many with low monthly premiums.

A PPO may be right for you if:

- Your favorite doctor already participates in the PPO (use our Doctor Finder tool to find out)
- You want some freedom to direct your own health care but don't mind working within a list of preferred providers

Part-Time Employee
For the purposes of qualifying for group health insurance, a part-time employee is one working between 20-29 hours per week.

Partial Disability
A condition in which, as the result of an illness or injury, a group health insurance member cannot perform all the duties of his or her occupation, but can perform some. Exact definitions differ between health insurance plans.

Partial Hospitalization Services
Also referred to as "partial hospital days," this is a healthcare term used to refer to outpatient services performed in a hospital setting as an alternative or follow-up to inpatient mental health or substance abuse treatment.

Participating Provider
Generally, this term is used in a sense synonymous with Network Provider. However, not all healthcare providers contract with health insurance companies at the same level. Some providers contracting with insurers at lower levels may sometimes be referred to as "participating providers" as opposed to "preferred providers."

Peer Review
This term refers to the process by which a physician or team of healthcare specialists review the services, course of medical treatment, or the conclusions of a scientific medical study conducted by another physician or group of medical experts. Peer review must be provided by a physician or team of medical experts with training and expertise equal to the physician or team conducting the treatment or research in question.

Periodic Health Exam
Typically, a periodic health exam is an exam that is occurs on a regular basis for preventative purposes, like a routine physical or annual check-up.

Periodic OB-GYN Exam
Typically, a periodic OB-GYN exam is a routine OB-GYN exam that occurs on a regular basis, typically for preventative purposes, like a PAP smear.

Physical Therapy
Typically, physical therapy services include rehabilitative services provided by a licensed physical therapist to help restore bodily functions such as walking, speech, the use of limbs, etc.

Place of Service
The type of facility in which healthcare services were provided, whether it be the home, hospital, clinic, office, etc..

Plan Name
The name of the health plan offered by the insurance company.

Plan Type

PPO
PPO means "Preferred Provider Organization." Like the name implies, with a PPO plan you'll need to get your medical care from doctors or hospitals on the insurance company's list of preferred providers if you want your claims paid at the highest level. You will probably not be required to coordinate your care through a single primary care physician, as you would with an HMO, but it's up to you to make sure that the health care providers you visit participate in the PPO. Services rendered by out of network providers may not be covered or may be paid at a lower level. A broad variety of PPO plans are available, many with low monthly premiums.

A PPO may be right for you if:

- Your favorite doctor already participates in the PPO (use our Doctor Finder tool to find out)
- You want some freedom to direct your own health care but don't mind working within a list of preferred providers

HMO
HMO means "Health Maintenance Organization." HMO plans offer a wide range of health care services through a network of providers that contract exclusively with the HMO, or who agree to provide services to members at a pre-negotiated rate. As a member of an HMO, you will need to choose a primary care physician ("PCP") who will provide most of your health care and refer you to HMO specialists as needed. Some HMO plans require that you fulfill a deductible before services are covered. Others only require you to make a copayment when services are rendered. Health care services obtained outside of the HMO are typically not covered, though there may be exceptions in the case of an emergency.

An HMO may be right for you if:

- You're willing to play by the rules and coordinate your care through a primary care physician
- You're looking for comprehensive benefits at a reasonable monthly premium
- You value preventive care services: coverage for checkups, immunizations and similar services are often emphasized by HMOs

Network
A "Network" plan is a variation on a PPO plan. With a Network plan you'll need to get your medical care from doctors or hospitals in the insurance company's network if you want your claims paid at the highest level. You will probably not be required to coordinate your care through a single primary care physician, as you would with an HMO, but it's up to you to make sure that the health care providers you visit participate in the network. Services rendered by out of network providers may not be covered or may be paid at a lower level.

A Network plan may be right for you if:

- Your favorite doctor already participates in the network (use our Doctor Finder tool to find out)
- You want some freedom to direct your own health care but don't mind working within a network of preferred providers

POS
POS stands for "Point of Service." POS plans combine elements of both HMO and PPO plans. As a member of a POS plan, you may be required to choose a primary care physician who will then make referrals to specialists in the health insurance company's network of preferred providers. Care rendered by non-network providers will typically cost you more out of pocket, and may not be covered at all.

A POS plan may be right for you if:

- You're willing to play by the rules and possibly coordinate your care through a primary care physician
- Your favorite doctor already participates in the network (use our Doctor Finder tool to find out)

Indemnity
Also called "fee-for-service" plans, Indemnity plans typically allow you to direct your own health care and visit whatever doctors or hospitals you like. The insurance company then pays a set portion of your total charges. You may be required to pay for some services up front and then apply to the insurance company for reimbursement. Indemnity plans typically require that you fulfill an annual deductible. Because of the freedom they allow members, Indemnity plans are sometimes more expensive than other types of plans.

An Indemnity plan may be right for you if:

- You want the greatest level of freedom possible in choosing which doctors or hospitals to visit
- You don't mind coordinating the billing and reimbursement of your claims yourself

EPO (Exclusive Provider Organization).
An EPO is a Exclusive Provider Organization. As a member of an EPO, you can use the doctors and hospitals within the EPO network, but cannot go outside of the network for care. There are no out-of-network benefits.

Policy Form Number
A unique number that identifies each health insurance policy filed with a state's department of insurance.

Policy Term
The period of time for which a health insurance policy provides coverage.

Practical Nurse
A licensed nurse who provides "custodial" care services, such as assistance in walking, bathing, feeding, etc.. Practical nurses do not administer medications or perform other strictly medical services.

Pre-Admission Authorization
-see Preauthorization/Precertification #2.

Preauthorization/Precertification
These are terms that are often used interchangeably, but which may also refer to specific processes in a health insurance or healthcare context.

1) Most commonly, "preauthorization" and "precertification" refer to the process by which a patient is pre-approved for coverage of a specific medical procedure or prescription drug. Health insurance companies may require that patients meet certain criteria before they will extend coverage for some surgeries or for certain drugs. In order to pre-approve such a drug or service, the insurance company will generally require that the patient's doctor submit notes and/or lab results documenting the patient's condition and treatment history.

2) The term "precertification" may also be used to the process by which a hospital notifies a health insurance company of a patient's inpatient admission. This may also be referred to as "pre-admission authorization."

Pre-existing Condition
A health problem that existed or was treated before the effective date of your health insurance coverage. Most health insurance contracts have a pre-existing condition clause that describes conditions under which the health insurance company will cover medical expenses related to a pre-existing condition. For more information, see also Pre-existing Condition Exclusion.

Pre-existing Condition Exclusion
see Pre-existing Condition. In some cases, a health insurance company may exclude a patient's pre-existing conditions from coverage under a new health insurance plan. This is more typical with individual and family health insurance plans and less common with group health insurance plans. HIPAA legislation imposes certain limitations on when a health insurance company can exclude coverage for a pre-existing condition.

Premium
The total amount paid to the insurance company for health insurance coverage. This is typically a monthly charge. Within the context of group health insurance coverage, the premium is paid in whole or in part by the employer on behalf of the employee or the employee's dependents.

Prescription Medication
A drug that may be obtained only with a doctor's prescription and which has been approved by the Food and Drug Administration.

Prescription Drug Coverage
Prescription drug coverage varies by carrier and plan type. Typically, prescription drugs are covered in one of the two ways below:
- Insurance covers a percentage after plan deductible is met.
- Insurance covers cost of the drug but a copay is required with prescription.

Preventive Care
Medical care rendered not for a specific complaint but focused on prevention and early-detection of disease. This type of care is best exemplified by routine examinations and immunizations. Some health insurance plans limit coverage for preventive care services, while others encourage such services. Note that well-baby care, immunizations, periodic prostate exams, pap smears and mammograms, though considered preventive care, may be covered even if your health insurance plan limits coverage for other preventive care services.

Primary Care
Basic healthcare services, generally rendered by those who practice family medicine, pediatrics or internal medicine.

Primary Care Physician (PCP)
A patient may be required to choose a primary care physician (PCP). A primary care physician usually serves as a patient's main healthcare provider. The PCP serves as a first point of contact for healthcare and may refer a patient to specialists for additional services.

Primary Coverage
If a person is covered under more than one health insurance plan, primary coverage is the coverage provided by the health insurance plan that pays on claims first. See also, COB.

Prior Authorization
-see Preauthorization/Precertification #1.

Probationary Period
A waiting period determined by the health insurance company during which coverage for certain pre-existing conditions may be excluded.

Provider
A term commonly used by health insurance companies to designate any healthcare provider, whether a doctor or nurse, a hospital or clinic.

Provider Write-off
The difference between the actual charge and the allowable charge, which a network provider cannot charge to a patient who belongs to a health insurance plan that utilizes the provider network. See Allowable Charge for more information.

Qualifying Event
An event (such as termination or employment, divorce or the death of the employee) that triggers a group health insurance member's protection under COBRA. See COBRA for more information.

Rating Process
The process by which a premium or rate for a group is determined. Items that may be considered in the rating process include age, sex, type of industry, benefits and administrative costs.

Reasonable and Customary Charges
-see Usual, Customary and Reasonable (UCR) Charge.

Referral
The process through which a patient under a managed care health insurance plan is authorized by his or her primary care physician to a see a specialist for the diagnosis or treatment of a specific condition.

Registered Nurse (RN)
A licensed professional nurse with a four-year nursing degree, trained to provide all levels of nursing care including the administration of medication.

Renewal
Renewal occurs when a member continues coverage under a health insurance plan beyond the original time frame of the contract. At the end of each benefit year, a plan member is generally invited to renew his or her coverage.

Renewal Date
The date on which a member's health insurance plan benefit year renews.

Respite Care
Normally associated with hospice care, respite care is a benefit often made available for family members of a patient, providing the patient's primary caretaker with a break or respite from caring for the patient. Respite care may be provided for the patient in either the home or a nursing home setting.

Rider
An amendment or modification to an insurance contract. See also, Benefit Riders.

Schedule C
The federal tax form used to report business income or business losses. A copy of this form may be required when applying for a group health insurance plan.

Schedule K-1
The federal tax form used to report a business partner's share or the income, credits and deductions from a business organized as a partnership. This is submitted to the federal government with the partner's federal tax return. A copy of this form may be required when applying for a group health insurance plan.

Second Surgical Opinion
Some health insurance companies may require a second opinion from a qualified physician or specialist before extending coverage for certain surgical procedures.

Secondary Care
Medical care rendered by a specialist (e.g. urologist, cardiologist) rather than a primary care physician. See also Primary Care and Tertiary Care.

Secondary Coverage
When a person is covered under more than one health insurance plan, this term describes the health insurance plan that provides payment on claims after the primary coverage. See also Primary Coverage and COB.

Self-funded Health Insurance Plan
A health insurance plan that is funded by an employer rather than through a health insurance company. A health insurance company will typically handle the administration of such a plan, but the cost of claims will be paid for by the employer through a fund set up for this purpose. See also, Administrative Services Only (ASO) Agreement.

Service Area
The geographic area in which a health insurance plan's benefits are made available. Some health insurance plans will not provide coverage outside of a plan's service area.

Short-term Plans
Short-term health insurance plans are similar to individual and family health insurance plans. However, coverage typically extends for no more than 6 months and benefits are often less comprehensive than those provided by a long-term health insurance plan.

Skilled Nursing Care
Intensive care usually required around the clock and rendered by, or under the supervision of, a Registered Nurse or licensed Practical Nurse. It is provided only when prescribed by a doctor and usually on an inpatient basis at a hospital or skilled nursing facility. Skilled nursing care may include the administration of medications, tube feeding, the changing of wound dressings, and some types of minor surgery.

Specialist
A doctor who does not serve as a primary care physician, but who provides secondary care, specializing in a specific medical field. See also, Secondary Care.

Standard Industrial Classification (SIC) Codes
These are codes used to describe or classify businesses based upon the products or services they provide. When you apply for group health insurance coverage, you may be asked to provide the SIC code for your business. This code provides the insurance company with information about the kind of work your employees are likely to perform and may be used to help determine a monthly premium.

Subrogation
The process by which a health insurance company determines whether medical bills should be paid for by the health insurance company itself or by another insurer or third party. For example, claims are frequently subject to subrogation when medical care is rendered as the result of an automobile accident. In most cases the automobile insurer is considered the primary payer. When a health insurance company has determined through the subrogation process that the automobile insurer will no longer pay on medical claims, then the health insurance company will typically become the primary payer.

Subscriber
This term may be used in two senses: First, it may refer to the person or organization that pays for health insurance premiums; Secondly, it may refer to the person whose employment makes him or her eligible for group health insurance benefits.

Temporary Partial Disability
This term is used to describe a the condition of a person who due to injury is unable to work at full capacity but who is able to work at reduced efficiency and is expected to fully recover.

Temporary Total Disability
This term describes the condition of a person who due to injury is unable to work, but who is expected to fully recover.

Tertiary Care
This term is used to describe services rendered by such specialized providers as intensive care units, neurologists, neurosurgeons and thoracic surgeons. Such services frequently require highly sophisticated equipment and facilities.

Terminally Ill
In healthcare and insurance usage, this term is used to describe a person who is not expected to live beyond six months due to a specific illness.

Treatment Facility
May refer to any facility, either residential or non-residential, which is authorized to provide treatment for mental illness or substance abuse.
Triage
A method of classifying sick or injured patients according to the severity of their conditions in order to ensure that medical facilities and staff are most effectively utilized.

Underwriting
The process by which an insurer determines whether it will accept an application for insurance based upon risks and projections, and through which a determination on monthly premium is made.

Uniform Billing Code of 1992 (UB-92)
The Uniform Billing Code of 1992 set industry-wide standards for medical billing practices.

Usual, Customary and Reasonable (UCR) Charge
This refers to the standard or most common charge for a particular medical service when rendered in a particular geographic area. It is often employed in determining Medicare payment amounts.

Utilization
This term refers to how frequently a group uses the benefits associated with a particular health insurance plan or healthcare program.

Utilization Management/Review
This term is often used to describe a group (or the work performed by a group) of nurses and doctors who work with health insurance plans to determine if a patient's use of healthcare services was medically necessary, appropriate, and within the guidelines of standard medical practice. Utilization Management/Review may also be referred to as Medical Review.

Vision Care Coverage
An insurance plan typically offered only on a group basis which covers routine eye examinations and which may also cover all or part of the costs associated with contact lenses or eyeglasses.

W-2
The federal tax form used to report an employee's wages and taxes.

Waiting Period
A period of time (often 12 months) beginning with your effective date during which your health insurance plan does not provide benefits for pre-existing conditions. This period may be reduced or waived based on any prior health care coverage you had before applying for your new health insurance plan.

Waiver (Exclusion Endorsement)
An agreement under which a member agrees to waive coverage for specific pre-existing conditions or for specific future conditions.

Waiver of Premium
In some cases, a waiver of premium may be granted, allowing a member to maintain health insurance coverage in full force without payment. A waiver of premium is typically only granted in cases of permanent and total disability.

Well-Baby/Well-Child Care
Regularly scheduled, preventive care services, including immunizations, provided to children up to an age specified by a health insurance company or mandated by a government agency. HMO and POS plans typically provide coverage for well-baby care, though coverage for these services may be limited under a PPO plan.

Well-Woman Care
A term sometimes used by insurance companies and healthcare providers to refer to mammograms and pap smears and other preventive care services rendered to a woman.