INSURANCE TERMS

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

Carrier: The insurance company or HMO offering a health plan

Claim: A request of payment made by an individual (or their provider) to an individual's insurance company for services obtained from a health care professional.

COBRA: Federal legislation allowing one to continue to purchase health insurance for up to 18 months, for someone who works for an insured employer group of 20 or more employees, in the event that the job is lost or the employer-sponsored coverage is terminated.

Copayment: The patient-paid portion of covered medical costs for those in a contract with a health plan. In a typical plan, the patient's copayment is printed on the card and is routinely $25 to $50.00.

Coinsurance: The percentage share of covered medical costs that the patient pays, with the insurance company paying an amount based on the patient's policy. Examples are: 20% / 80% wherein the patient is responsible for 20% of the allowed charges.

Coordination of Benefits: Occurs when a patient is eligible for coverage by more than one insurance plan. The benefits of the plans are coordinated so that the patient may receive up to 100% coverage for his or her medical costs.

CPT Code: A code number developed by the American Medical Association used to identify medical services. CPT stands for “Current Procedural Terminology”.

Deductible: The total amount of covered medical care expenses that must be paid by the patient, usually on an annual basis, *before* the insurance company begins paying benefits.

Denial Of Claim: Refusal by an insurance company or carrier to honor a request by an individual (or their 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 person.

Effective Date: The date the insurance begins. Coverage does not begin until the effective date of the policy.

Exclusion: A condition or circumstance for which a health plan does not provide benefits.

Explanation of Benefits: The insurance company's written explanation to a claim, showing what they paid and what the client is responsible to pay. In some cases, it is accompanied by a benefits check.

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

Health Maintenance Organizations (HMOs): 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 HMO, services may be provided in a central facility or in a physician's own office (as with IPAs.)

HIPAA: The Health Insurance Portability and Accountability Act of 1996." Is a federal law that was passed in 1996 allowing persons to qualify immediately for comparable health insurance coverage when they changed their employment or relationships. It also created 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.

ICD-9 Code: The "International Classification of Disease" code that indicates the diagnosis of illness, disease, or trauma for which care was rendered.

In-network: Providers that are part of a health plan's network 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 basis, not group basis. The premium is usually higher for an individual health insurance plan than for a group policy. Not everyone qualifies for a group plan.

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 insured's Certificate of Insurance.

Managed Care: A medical delivery system that attempts to manage the quality and cost of medical services an individual receives. 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.

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.

Network: A group of doctors, hospitals and other health care providers contracted to provide services to insurance company's 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.

Out-of-Network: This phrase usually refers to physicians or other health care providers who are considered non-participants (no contract held) 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 only partly covered by the 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% of the individual's health care expenses.

Pre-authorization letter: A letter written by a physician to an insurance company prior to a procedure. It explains, in detail, the procedure a patient plans to have and requests confirmation that the patient is covered, the planned services are covered, and verifies the level of coverage for the planned services.

Pre-determination: A review process conducted by an insurance company to verify the medical necessity of a planned procedure or treatment. Pre-determination is often a condition of plan payment.

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

Preferred Provider Organizations (PPOs): A plan in which an individual or their employer receives discounted rates if the doctors used are from a pre-selected group. If a physician is used outside of the PPO plan, the cost of the medical care will be more.

Private Health Insurance: Insurance plans marketed by the private health insurance industry. Approximately two-thirds of the non-elderly population is covered by private health insurance. Coverage includes policies obtained either through employer-sponsored insurance as a benefit of employment or bought outside of the workplace on the individual health insurance market.

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 guaranteed to pay 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.

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