Glossary of Insurance Terms

Acute care
Short-term medical care provided for serious acute illness or episode.

Allowable charges
The specific dollar amount of a medical bill that one’s health plan, Medicare or Medicaid will pay for covered services.

Ambulatory care
Outpatient medical care provided for an injury or an illness.

Ancillary services
Supplemental services ordered by your physician needed to provide care such as laboratory, radiology, durable medical equipment (DME) and pharmacy services.

Arbitration
Procedure in which an insurance company and the insured or a vendor agree to settle a claim dispute by accepting a binding or non-binding decision made by a third party.

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

Capitation
A per-capita payment made by the health plan per enrollee to provider to cover all necessary care for an employee.

Carrier
The insurance company or HMO offering a health plan.

Case Management
A system of coordinating medical services to treat a patient, improve care, and reduce cost. A case manager coordinates health care delivery for patients.

Certificate of Coverage
The document you receive from your health plan that explains what health care services your plan will pay for, what services you may have to pay for, and what rules you must follow to receive the services.

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.

Charity Care
Free medical care. Providers of medical care usually have a written policy that states which patients can receive free medical care and for what services (usually medically necessary).
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.

COBRA
Consolidated Omnibus Budget Reconciliation Act, a federal law in effect since 1986. COBRA permits you and your dependents to continue in your employer's group health plan after your job ends. If your employer has 20 or more employees, you may be eligible for COBRA continuation coverage when you retire, quit, are fired, or work reduced hours. Continuation coverage also extends to surviving, divorced or separated spouses, dependent children, and children who lose their dependent status under their parent's plan rules. You may choose to continue in the group health plan for a limited time and pay the full premium (including the share your employer used to pay on your behalf) plus a 2% administrative fee. COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances.
*See also State Continuation Coverage.

Coinsurance
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.

Continuous Coverage
Health insurance coverage that is not interrupted by a break of 63 or more days in a row. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Creditable Coverage, Federally Eligible.

Coordination of Benefits (COB)
Rules and procedures that determine how health care claims are paid when you are covered by more than one health insurance plan. Together, the health plans cannot pay more than the charge for the services.

Copayment
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.

Covered Expenses
In health insurance, reimbursement for an insured's medically-related expenses; including, but not limited to surgery, medicines, hospitalization, ambulance service, and X-rays.

Credentialing
The review process used by an insurer or health plan to determine which health care providers are qualified to provide services to health plan members. Items such as the provider’s license, certification, malpractice insurance, and history are examined.
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.

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

Elective procedure
A medical procedure that a patient and doctor plan in advance for a condition that is not life threatening.

Emergency care
Medical care that is needed immediately to save your life or to prevent serious harm to your health.

Emergency Medical Services (EMS)
Emergency care provided by ambulance personnel such as EMTs (emergency medical technicians), paramedics, first responders or other authorized individuals.

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

Exclusive Provider Organization (EPO)
Least standard type of insurance. Different EPOs have different rules. Some plans are more restrictive than others. Providers are contracted and agree to discount charges. Contracted providers are referred to as “exclusive” and in most cases members may only see exclusive providers.

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.

Family Practitioner
A physician who provides primary health care for individuals and families.

Fee-for-Service
Traditional method of payment for health care services where specific payment is made for specific services rendered to the provider.

Fully Insured Group Health Plan
Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by the state of Iowa.

Gatekeeper
The health care provider, utilization review, case management, local agency or managed care entity who determines if a patient should see a specialist or receive other non-routine services. The goal of the gatekeeper is to guide the patient to appropriate services while avoiding unnecessary care.
**Group Insurance**  
Coverage through an employer or other entity that covers all individuals in the group.

**Health Insurance**  
Financial protection against all or part of the medical care costs to treat illness or injury. Health insurance may also include benefits for preventive health care to help you stay healthy.

**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).

**Health Plan**  
A policy of health insurance issued by a health maintenance organization, an insurance company, Blue Cross Blue Shield, a fraternal benefit society, or other authorized entity.

**Health Savings Account (HSA)**  
Account with tax-deductible contributions, tax-free interest earned, tax-free withdrawals for qualified medical expenses, and annual carry-over without limit for both funds and interest. Typically used in conjunction with high-deductible insurance plans or no insurance. Medicare patients are not qualified for HSA.

**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."

**Hospice**  
A facility or program that provides care for a terminally ill patient.

**Indemnity 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, IPAs, and PPOs. With indemnity plans, the individual pays a pre-determined percentage of the cost of health care services, and the insurance company (or self-insured employer) pays the other percentage. For example, an individual might pay 20 percent for services and the insurance company pays 80 percent. The fees for services are defined by the providers and vary from physician to physician. Indemnity health plans offer individuals the freedom to choose their health care professionals.
Independent Physician Association (IPA)
Network physicians can practice in an IPA (Independent Physician Association), where you visit the doctor’s office for care. A staff model where the health care company maintains a health care center, staffed with physicians and complete with lab, X-ray, pharmacy and other specialist services under one roof; or a combination of both, which is called a mixed model. CIGNA HealthCare offers these types of networks. Most of CIGNA HealthCare’s network plans also offer specialized benefits, including mental health and substance abuse, pharmacy, dental and vision care.

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

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.

Inpatient Care
Care provided to a patient requiring a bed who has been admitted to a health care facility to receive services.

Large Group Health Plan
A health plan with more than 50 eligible employees.

Lifetime Maximum
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.

Long-Term Care
Insurance policies that cover specified services for a specified period of time. Long-term care policies (and their prices) vary significantly. Covered services often include nursing care, home health care services, and custodial care.

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.

Managed Care Organizations (MCO)
A health plan that seeks to manage care. Examples: HMOs and IPAs.
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.

Maximum Out-of-Pocket Cost / Out-of-Pocket Limit
The total amount of money you may be required to pay each year for medical care under a health plan including deductibles, co-payments, co-insurance, etc.

Medicaid (Title XIX)
A health care program for people who meet certain income and other guidelines. Medicaid is paid for by federal and state dollars.

Medical Assistance
A Medicaid health care program for people who meet certain income and other guidelines. It is paid for by federal and state dollars.

Medically Necessary Care
Health care services that are generally accepted by health care providers to be appropriate to diagnose or treat a medical condition as well as preventative health services.

Medicare (Title XVIII)
A federal health insurance program for people over 65 and for certain people under 65 with disabilities or health conditions.

Medicare Supplemental Insurance
A secondary policy that covers certain medical expenses not fully covered by Medicare.

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.

Nurse Practitioner (NP)
A registered nurse specifically educated (generally Masters programs) and licensed to provide primary and/or specialty care.

Out-of-Network Provider
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 Costs
Health care expenses not covered by an insurer or HMO, including deductibles, co-insurance, and co-payments.
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.

Participating Providers
Health care providers who are under contract with an insurer or HMO.

Physician Assistant (PA)
A specifically trained physician extender who provides medical care under physician supervision.

Point of Service (POS)
POS is the most versatile type of insurance. Plans have “tiers”, also called “levels” or “options”. Members may select from these tiers for each service received. Each tier has different rules: Tier 1 works like an HMO; Tier 2 works like a PPO in network and Tier 3 works like a PPO out-of-network. This is a method of influencing patients without restricting choice too much.

Policy Limit
The maximum amount a policy will pay, either overall or under a particular coverage.

Pre-Certification (Pre-Admission Review)
- A review of an individual’s health care status or condition, prior to an individual being admitted to a hospital. Pre-admission reviews are often conducted by case managers or insurance company representatives (usually nurses) in cooperation with an individual’s health care provider, and or hospitals.
- Pre-cert nurses exchange clinical information with Insurance companies as well as continued stay review with documentation and number of days.

Pre-Existing Condition
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.

Pre-Existing Condition Exclusion Period
The time during which a health plan will not pay for covered care relating to a preexisting condition. *See also Preexisting Condition

Prepaid Health Plan (PHP)
Entity that contracts on a prepaid, capitated risk basis to provide services that are no risk-comprehensive services, or contracts on a non-risk basis.
Preferred Provider Organization
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.

Premium
The amount that you and/or your employer pay for health insurance, usually paid in installments.

Preventive Care
Health care that focuses on healthy behavior and providing services that prevent health problems. This includes health education, immunizations, early disease detection, health evaluations and follow-up care.

Primary Care
Basic health care services rendered by physicians in general practice or in fields such as family practice, obstetrics, and pediatrics.

Primary Care Providers (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.

Prior Authorization
Pre-approval for a specified service or procedure; used to determine if the proposed treatment is deemed medically necessary for the health of the patient.

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.

Quality Assurance
Activities to ensure and improve the quality of medical care that is provided by reviewing the care and working to correct any problems.

Referral
A referral is a pre-approval from a patient’s primary care physician to receive care from a different provider or facility. Health Maintenance Organizations (HMO) insurance plans require a referral (authorization) to obtain coverage for outside services. Insurance companies use varying terminology for referral such as ‘Gap Exception’ or ‘Exception of Benefit’. Some insurance plans have a point of service (POS) option which allows patients to seek services from a physician/hospital that falls outside the HMO network and pay a greater percentage/out of pocket for the services received from an out of network health care provider.
Reinsurance
Insurance by another insurer of all or a part of a risk previously assumed by an insurance company. (Webster)

Reinsurance essentially is insurance for insurance companies (and, sometimes, for other organizations that face risk, such as employers that self-insure their employees' health care costs). As with so many other types of insurance policies, reinsurance is not activated until a deductible is met; and there is a "ceiling," or upper limit, on reinsurable expenses. Reinsurance policies also have coinsurance rates (amounts that the policyholder must pay for particular services) that apply to expenses between the deductible and ceiling.

Insurers typically worry about two types of very large losses—aggregate losses for a group being above some overall level, and loss per insured person exceeding some threshold. Aggregate losses could exceed expectations if more group members had expenses above the average than was expected for the group. In this case, the insurer would not have set premiums high enough to cover those aggregate losses. To place a limit on their exposure to such expenses, insurers often purchase reinsurance. In such cases it is known as aggregate stop-loss reinsurance, since it puts a stop to overall losses above some level.

Respite Care
Providing patient care so the primary caregiver can rest or take time off.

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

Self-Insured Group Health Plans
Plans set up by employers who set aside funds to pay their employees' health claims. Because employers often hire insurance companies to run these plans, they may look to you just like fully insured plans. Employers must disclose in your benefits information whether an insurer is responsible for funding, or for only administering the plan. If the insurer is only administering the plan, it is self-insured. Self-insured plans are regulated by the U.S. Department of Labor, not by the state of Iowa.

Self-Pay Patients
Individuals who pay out-of-pocket for the medical care they receive as they are not covered under an insurance plan or assistance program such as Medicaid. Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA): As a component of Medical Assistance, TEFRA helps families cover health care costs for their severely disabled children who would otherwise require institutional-level care.

Subrogation
The legal process by which an insurance company, after paying for a loss, seeks to recover the amount of the loss from another party who is legally liable.

Tertiary Care
Highly specialized medical care that may require the use of specialized medical facilities.
Third-Party Administrator
Outside group that performs clerical functions for an insurance company. An organization, public or private, which pays or insures for the health care services on behalf of the beneficiaries or recipients.

Underwriting
Process of assessing and assuming the risk of enrolling an individual or a group in a health plan.

Underinsured
People with inadequate health insurance that does not cover all necessary medical care.

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

Worker’s Compensation
A state-mandated program requiring employers to pay benefits and furnish medical care to employees for on-the-job injuries and to pay benefits to dependents of employees killed in the course of employment.