

Glossary of Insurance Terms

Account: An agreement a managed care company may have with an employer, or government. A care management team at the Insurance Company may be devoted to one account or employer group.

Affordable Care Act (ACA): The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or “Obamacare”).

Appeal: A request for the health insurance company or the Health Insurance Marketplace to review a decision that denies a benefit or payment.

Audit: A review of a providers file on a particular client or group of clients by the health plan in order to assure that quality of care and to be sure the provider is following insurance procedures.

Authorization: Getting approval from the health plan before a routine hospital stay or outpatient procedure.

Allowable charge: Sometimes known as the "allowed amount," "maximum allowable," and "usual, customary, and reasonable (UCR)" charge, this is the dollar amount considered by a health insurance company to be a reasonable charge for medical services or supplies based on the rates in your area.

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

Behavioral care services: Assessment and therapeutic services used to treat mental health and substance abuse problems.

Benefit: The amount payable by the insurance company to a plan member for medical costs.

Benefit level: The maximum amount that a health insurance company has agreed to pay for a covered benefit.

Benefit year: The 12-month period for which health insurance benefits are calculated, not necessarily coinciding with the calendar year. Health insurance companies may update plan benefits and rates at the beginning of the benefit year.

Carrier: An insurance company is often referred to as the insurance carrier.

Carve-out: A carve-out insurance plan is a supplement to a person's standard health insurance plan. The carve-out plan is provided by a third-party vendor, and it covers specialized care or products, such as prescription medications and treatment for chronic illnesses.

Case Management: A method by which a health plan attempts to control costs by directing all of the procedures for care of an individual through a nurse or other health care professional.

Certified Employee Assistance Professional (CEAP): A health care professional who has gone through the additional training classes required to become a CEAP.

Claim: A request by a plan member, or a plan member's health care provider, for the insurance company to pay for medical services.

CMS-1500 (Center for Medicare and Medicaid Services Form 1500): This is a claim form that is accepted by most private and federal health insurance plans.

Coinsurance: The amount an individual pays to share the cost of covered services after the deductible has been paid. The coinsurance rate is usually a percentage.

Continuity of care: Continuity of care is concerned with quality of care over time. It is the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care.

COBRA coverage: Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates. The law generally covers health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments. Many states have "mini-COBRA" laws that apply to the employees of employers with less than 20 employees.

Contract rate, or contracted fee: The fee the insurance company will pay for a session, as outlined in the network provider contract. This is usually a discounted fee from the provider's usual full fee.

Conventional indemnity plan: An indemnity that allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred.

Coordination of benefits: A system used in group health plans to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100% of the claim.

Co-payment: One of the ways an individual shares in medical costs.

Coverage: When a person signs up for a health plan, the plan provides protection ("coverage") for medical expenses the person or any dependents may incur during the plan year.

Covered services: The services the health plan will pay for according to the agreement between the health care carrier and either the employer group or the individual.

CPT Codes: Current Procedural Terminology (CPT) is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

Credentialing: A process used by the insurance company in which a health plan provider's credentials are reviewed and matched against the credentials required to participate in the provider network.

Date of service: The date the customer received the service.

Deductible: The amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying.

Dependent: Any individual, either spouse or child, that is covered by the primary insured member's plan.

Dispute: Also known as an appeal. A providers written notice to the insurance company challenging, appealing, or requesting reconsideration of a claim that has been denied, adjusted, or contested, or disputed a request for reimbursement of an overpayment of a claim.

Dispute Resolution: The process that each insurance plan has set up for handling and settling disputes.

Double (or duplicate) coverage: When a client has coverage under more than one health benefits plan.

DSM: The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is the 2013 update to the American Psychiatric Association's (APA) classification and

diagnostic tool. In the United States the DSM serves as a universal authority for psychiatric diagnoses.

EIN (Employer Identification Number): This is a type of Tax Identification Number (TIN) that any business can obtain from the Internal Revenue Service. The EIN can be used on claims and invoices in place of a providers Social Security Number.

Effective date: The date on which a policyholder's coverage begins.

Eligibility: Details contained in each health coverage plan that specify who qualifies for coverage under that plan.

ERISA: The Employee Retirement Income Security Act of 1974 is a comprehensive and complex statute that federalizes the law of employee benefits. ERISA applies to most kinds of employee benefit plans, including plans covering health care benefits, which are called employee welfare benefit plans.

Employee Assistance Program (EAP): An EAP is an assessment and referral program or a short-term counseling program that is pre-purchased by some employers and is typically available to their employees, their dependents and household members. EAPs are separate from behavioral health care coverage plans and are typically available to employees at no additional cost whether or not they are enrolled in their employer-sponsored health plan.

Enrollee: An individual who is offered health coverage by his or her employer.

Exclusion or limitation: Any specific situation, condition, or treatment that a health insurance plan does not cover.

Explanation of benefits (EBO): The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs an individual is responsible for.

Exclusive provider organization (EPO) plan: A more restrictive type of preferred provider organization plan under which an individual must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.

Fee-for-service plans: A healthcare plan in which providers receive payment based on their billed charges for each service provided without treatment review or authorization. These plans are not considered "manages care," plans and allow visits to any health professional.

FSA (Flexible Spending Account): An FSA is often set up through an employer plan. It lets you set aside pre-tax money for common medical costs and dependent care. FSA

funds must be used by the end of the term-year. It will be sent back to the employer if you don't use it.

Group health insurance: A coverage plan offered by an employer or other organization that covers the individuals in that group and their dependents under a single policy.

Health maintenance organization (HMO): A health care financing and delivery system that provides comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific, in-network plan providers.

Health savings account (HSA): A personal savings account that allows participants to pay for medical expenses with pre-tax dollars. HSAs are designed to complement a special type of health insurance called an HSA-qualified high-deductible health plan (HDHP). HDHPs typically offer lower monthly premiums than traditional health plans.

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

HIPAA (Health Insurance Portability and Accountability Act of 1996): Health Insurance Portability and Accountability Act of 1996 is federal legislation that provides data privacy and security provisions for safeguarding medical information.

HRA (Health Reimbursement Account): An account that lets an employer set aside funds for healthcare costs. These funds go to reimburse Covered Services paid for by employees who take part. An HRA has tax benefits for employer and employees.

ICD: The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States. It is maintained by the World Health Organization.

Indemnity plan: A type of medical plan that reimburses the patient and/or provider as expenses are incurred.

Insured: The individual who is enrolled and eligible for coverage under a health plan.

Invoice: Also known as a statement or superbill. A list of charges and payments made for healthcare services. Out of network providers may give these to a client to submit to their insurance plan for reimbursement.

In-network provider: A health care professional, hospital, or pharmacy that is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers because they have negotiated a discount for their services in exchange for the insurance company sending more patients their way.

Individual health insurance: Health insurance plans purchased by individuals to cover themselves and their families. Different from group plans, which are offered by employers to cover all of their employees.

Lifetime Maximum: Lifetime maximum or lifetime limits refers to 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. For plan or policy years beginning on or after Sept. 23, 2010, plans may not establish any lifetime limit on the dollar amount of benefits for any individual. All plans are required by PPACA to remove the lifetime maximum restrictions, however this is subject to change.

Managed care plans: Managed care plans generally provide comprehensive health services to their members, and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include:

- ◆ Health maintenance organizations (HMOs)
- ◆ Preferred provider organizations (PPOs)
- ◆ Exclusive provider organizations (EPOs)
- ◆ Point of service plans (POSs)

Maximum Out-Of-Pocket Costs: An annual limitation on all cost-sharing for which patients are responsible under a health insurance plan. This limit does not apply to premiums, balance-billed charges from out of network health care providers or services that are not covered by the plan.

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

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.

MH/SA: An abbreviation used by insurers to refer to Mental Health and Substance Abuse benefits. Do not confuse with MHSA, which can mean "Mental Health Service Administrators" indicating there may be a carve-out for mental health benefits to another plan, a "Mental Health Service Administrators."

Medicaid: A health insurance program created in 1965 that provides health benefits to low-income individuals who cannot afford Medicare or other commercial plans. Medicaid is funded by the federal and state governments, and managed by the states.

Medicare: The federal health insurance program that provides health benefits to Americans age 65 and older. Signed into law on July 30, 1965, the program was first

available to beneficiaries on July 1, 1966 and later expanded to include disabled people under 65 and people with certain medical conditions.

Medicare supplement plans: Plans offered by private insurance companies to help fill the "gaps" in Medicare coverage.

Medical savings accounts (MSA): Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and a Medical Savings Account (MSA) is the ability under an MSA to carry over the unused funds for use in a future year, instead of losing unused funds at the end of the year. Most MSAs allow unused balances and earnings to accumulate. Unlike FSAs, most MSAs are combined with a high deductible or catastrophic health insurance plan.

National Provider Identifier (NPI): A National Provider Identifier or NPI is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).

Network: The group of doctors, hospitals, and other health care providers that insurance companies contract with to provide services at discounted rates.

Network provider: Any health care provider who has entered into an agreement with a managed care plan, and thus belongs to the insurance plan's network of providers.

Open enrollment: A period when eligible persons can enroll in a new health benefit plan for the next benefit year.

Out-of-network provider: A health care professional, hospital, or pharmacy that is not part of a health plan's network of preferred providers.

Out-of-pocket maximum: The most money an individual will pay during a year for coverage. It includes deductibles, copayments, and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Panel: The network of providers who have contracted with a health plan to provide services to the insurance members or enrollees. Also known as provider network.

Parity: State or federal law which requires insurance companies to grant some measure of equality between the benefits they provide for mental health and medical visits.

Participant: A person who is eligible to receive benefits under a health benefits plan. This may refer to the employee, spouse, or other dependents.

Participating provider: Any health care provider that has entered into an agreement with a managed care plan, and thus belongs to the insurance plan's network of providers. Choosing a participating provider (network provider) gives the member the advantage of discounted fees, not having to file their own claims and often a higher level of coverage by the health plans. Also called the provider network.

Payer: The health insurance company whose plan pays to help cover the cost of an individual's care. Also known as a carrier.

Pended claim: A claim that requires more information before it can be processed.

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

Pre-existing condition: A health problem that has been diagnosed, or for which an individual has been treated, before buying a health insurance plan.

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. 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.

Preferred provider organization (PPO): A health insurance plan that offers greater freedom of choice than HMO (health maintenance organization) plans. Members of PPOs are free to receive care from both in-network or out-of-network (non-preferred) providers, but will receive the highest level of benefits when they use providers inside the network.

Primary care physician (PCP): A physician who serves as a group member's primary contact within the health plan. In a managed care plan, the primary care physician provides basic medical services, coordinates and, if required by the plan, authorizes referrals to specialists and hospitals.

Premium: The amount that an individual or an employer pays each month in exchange for insurance coverage.

Provider: Any person (i.e., doctor, nurse, dentist, therapist) or institution (i.e., hospital or clinic) that provides medical care.

Provider network: A group of health care professionals contracted by a health care carrier to deliver medical services to its customers.

Point-of-service (POS) plan: A POS plan is an "HMO/PPO" hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (e.g., provider reimbursement based on a fee schedule or usual, customary and reasonable charges).

Policyholder: The individual to whom an insurance contract is issued, usually the employee in an employer-sponsored health plan. Also called the subscriber.

Portability: The ability for an individual to transfer from one health insurance plan to another and still be covered.

Private-pay agreement: An agreement between the client and provider where the client agrees to pay for services out of pocket.

Quality assurance: The steps taken by a managed care health plan to ensure quality care, including provider credentialing, auditing, treatment review, and other monitoring of provider care.

Re-credentialing: A process used by managed care companies in which a network providers information is updated and credentials are again reviewed and matched against the qualifications required to participate in the provider network. This is done at regular intervals.

Retro-authorization: An authorization for treatment given by an insurance company after the date of service has already passed.

Rider: Coverage options that enable you to expand your basic insurance plan for an additional premium. A common example is a maternity rider.

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.

Single case agreement: When an appropriate provider cannot be found who is available to provide services within a reasonable distance from the client and within the clients provider network, or when no network providers have the specialized training or expertise a client needs, a health plan may often be compelled to contract with an out of network provider to act as a network provider for this one case.

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.

Superbill: Also called an invoice. A list of charges and payments made for healthcare services. Out of network providers may give these to a client to submit to their insurance plan for reimbursement.

Telehealth: Providing treatment, education, and health services over a distance. While each state defines telehealth differently, it typically involves the application of both video and audio technologies in synchronous treatment delivery (some states include telephone in their definition).

TRICARE: The Defense Departments managed care plan for military and retirees.

Third party administrator (TPA): An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.

Third-party payer: Any payer for health care services other than the client.

Underwriting: The process by which health insurance companies determine whether to extend coverage to an applicant and/or set the policy's premium.

Usual, customary, and reasonable (UCR) charges: UCR charges mean that the charge is the provider's usual fee for a service that does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances.

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.

Waiting period: The period of time that an employer makes a new employee wait before they become eligible for coverage under the company's health plan. Also, the period of time beginning with a policy's effective date during which a health plan may not pay benefits for certain pre-existing conditions