

A

Accidental Death and Dismemberment (AD&D) Rider

A supplement to many life insurance policies that provides an additional cash benefit to the insured or his/her beneficiaries if an accident causes either the death of the insured or causes the insured to lose any two limbs or the sight in both eyes.

Annual out-of-pocket maximum

A dollar amount set by the plan which puts a cap on the amount of money the insured must pay out of his or her own pocket for covered expenses over the course of a calendar year.

Applicant

The person or business that applies for an insurance policy.

B

Beneficiary

The person or party the owner a life insurance policy names to receive the policy benefit in the event of the insured's death.

Brand-name (medications)

Prescription medications that are manufactured by the developer of the medication in question.

Broker

A commissioned sales agent who is under contract to and sells the insurance products of more than one insurance company.

C

Calendar-year deductible

An amount that the insured person must pay before insurance payments for covered services begin.

Case management

A utilization management technique that addresses the medical necessity of care as well as alternative treatments or solutions, especially when the patient is likely to require very expensive treatment.

Certificate of insurance

A document that describes the type and length of coverage provided by a group insurance policy that is given to each insured by the group policyholder.

Chiropractic care

Not all plans cover chiropractors -- practitioners who manipulate the spine and other structures within the body to relieve pain and tension resulting from posture, stress or strain. Some plans offer chiropractic care as an optional benefit.

Claim

A request for payment under the terms of an insurance policy.

Claim examiner

An insurance company employee who is responsible for carrying out the claim examination process. Also known as claim approver, claim analyst, or claim specialist.

Coinsurance provision

A specified percentage of the cost of treatment the insured is required to pay for all covered medical expenses remaining after the policy's deductible has been met.

Commission

The amount of money, usually a percentage of the premiums, that is paid to an insurance agent for selling an insurance policy.

Comprehensive major medical policy

A health insurance policy that covers both major medical coverages (i.e., hospitalization and surgeries) and basic medical expense coverages.

Copay

(1) A fee that many insurance plans require an insured to pay for certain medical services (such as a physician's office visit). (2) An amount that the insured must pay toward the cost of each prescription under a prescription drug plan.

D**Deductible**

A flat amount of covered medical expenses that an insured must incur before the insurer will make any benefit payments under a medical expense policy.

Dental -- benefits

Some health plans offer dental care as an optional benefit or rider that you or your employees may decide to add at an additional cost.

Dependent

A person for whom the insured has some legal obligation to. For most plans, it is the insured's spouse and/or children. Some plans also allow non-traditional spousal relationships (significant other, life-partner, etc.) to be considered a dependent with some additional certifying paperwork.

Domestic partner

Domestic partners are commonly defined as "two adults who share an emotional, physical and financial relationship similar to that of a married couple but who either choose not to marry or cannot legally marry. They share a mutual obligation of support for the basic necessities of life." Additionally, some carriers may require that domestic partners own property together to qualify.

Dual choice

Dual choice allows the employer to offer his employees not one, but two health plans. Instead of picking the least expensive plan for all employees, Dual Choice lets employees choose the type of plan that best meets their needs or budgets. Usually, this is a choice of an HMO and PPO, or HMO and POS. The employer will typically pay a portion of the premium in these plans, and the employee will pay the balance. Here are a few approaches:

- An employer may pay for the lower cost plan and employees may buy up to the more expensive plan.
- An employer may pay a set amount per month for every employee.
- An employer may charge all employees the same amount and pay the balance, regardless of the plan each employee selects.

E**Effective date**

The specified date of when the health insurance policy is to begin.

Emergency care

Most plans cover emergency care in a hospital emergency room if it is an extremely urgent medical emergency, even if the hospital you are taken to is not in the plan's network. It is possible, however, that after your condition has been stabilized, you would be transferred to a participating plan hospital.

Emergency-room visit

A visit to a hospital for treatment of an accidental injury or for emergency medical care. To qualify as an emergency, the symptoms must be sudden, severe and require immediate medical attention. Some states judge emergencies by the "prudent layperson" law, meaning that the health plan must cover a trip to the emergency room "if a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed." Keep in mind that some plans won't cover a trip to the emergency room if the symptoms appeared more than 24 hours earlier.

Employee contribution

The amount of premium the employer requires the employee to pay towards his or her health insurance.

Enrollment or eligibility period

The time during which a new group member may first enroll for group insurance coverage.

Exclusions and limitations

Conditions, situations and services not covered by the health plan.

F**Fee schedule payment structure**

A fee structure used by insurers under which the insurance company places caps or limits on the dollar amounts that it will reimburse providers covered medical procedures and services, both in and out-of-network if applicable. Also known as a limited fee schedule.

Fee-for-service plan

Also called an indemnity plan. A health insurance plan that allows the insured to use any medical provider that he or she chooses. As such, there are no networks to utilize.

Flex-term medical coverage

See "short-term medical coverage."

Formulary drugs

Formulary drugs generally have a lower copay. A formulary drug is one that has been thoroughly reviewed by a team of expert pharmacists and physicians; these drugs have been identified as safe, effective and beneficial to members for treating medical conditions. When deciding between drugs which are equally safe and effective, the formulary team also considers the relative costs of medications. These savings are then passed on to you through lower premiums.

Fully insured plan

A group insurance plan for which an insurance company bears the responsibility of making all claim payments.

Fully self-insured plan

A group insurance plan under which the employer takes complete responsibility for all claim payments and related expenses rather than purchasing coverage from an insurance company.

G**Gatekeeper**

A term used to describe the primary care physician's role in a managed care plan; this role is to authorize all services delivered to the insured by other physicians or health care providers. Thus, whenever you wish to see a physician other than your primary care physician, you must first obtain his or her permission (via a referral).

Generic (medications)

When a new drug is put on the market, the pharmaceutical company patents it under a brand name. The company has the exclusive right to sell the drug under this name, but once its patent expires, other companies can sell the same drug under its chemical, or generic, name. Generic drugs are typically cheaper than brand-name drugs, but the Food and Drug Administration requires generic drug manufacturers to show that a generic drug "delivers the same amount of active ingredient in the same time frame as the original product."

Group term life

A life-insurance plan that provides employees with additional coverage at economical group rates.

Guaranteed renewable policy

A health insurance policy that the insurer is required to renew -- as long as premiums are paid -- at least until the insured attains the age limit specified in the policy, or the policy is cancelled by the insured. The insurer may increase the premium rate for any class of guaranteed renewable policies.

H

Health care provider

A doctor, hospital, laboratory, nurse or anyone else who delivers medical or health-related care.

Health insurance

A type of insurance that provides protection against the risk of financial loss resulting from the insured person's sickness, accidental injury or disability.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Under this federal law (known as HIPAA), group health plans cannot deny coverage based solely on an individual's health status. This law also gives employees who change or lose their jobs better access to health coverage, guarantees renewability and availability to certain employees and limits exclusions for pre-existing conditions. For example, under this law, group health plans must credit any employee the amount of time that they spent on any health plan prior to the new plan, which is known as "prior credible coverage." A pre-existing condition will be covered without a waiting period when an employee joins a new group plan if the employee has been insured for the previous 12 months with credible health insurance, with no lapse in coverage of 63 days or more. This means that if an employee has been insured for 12 months or more, the employee will be able to go from one job to another and his or her pre-existing coverage will remain intact -- without additional waiting periods. However, if an employee has a pre-existing condition and was not covered previously for 12 months before joining a new plan, the longest the employee will have to wait for their pre-existing coverage to be covered is 12 months.

Health Maintenance Organization (HMO)

A health care financing and delivery system that provides comprehensive health care for subscribing members in a particular geographic area using managed care techniques. Most HMOs require that you only utilize physicians within their network, often going so far as to require you to choose a primary care physician who directs most courses of your treatment.

Home health care

Skilled medical care and other health care services that you receive in your home for the treatment of an illness or injury. Some insurance plans don't provide this kind of coverage, or provide it only for a limited amount of time.

I

Indemnity plan

Also called a fee-for-service plan. A health insurance plan that allows the insured to use any medical provider that he or she chooses. As such, there are no networks to utilize.

Individual Practice Association (IPA)

A type of open-panel HMO that contracts with an association of physicians who agree to provide services for HMO members.

Inpatient surgery

Medical procedures which require the patient to spend at least one night at the hospital. Most plans limit the amount of time an inpatient may stay at the hospital following surgery.

Insurance agent

A person authorized by an insurance company to represent the company in its dealings with applicants for insurance.

Insured

The person whose life or health is insured under an insurance policy. Also referred to as a "member."

J

Sorry, we have no glossary items beginning with the letter "J".

K

Sorry, we have no glossary items beginning with the letter "K".

L**Life dependent**

This option is offered by some plans to provide a set amount of life insurance for the insured's spouse, domestic partner or children.

Lifetime maximum

The maximum amount of money a plan will pay towards healthcare services over the course of the insured's lifetime.

M**Major medical insurance plan**

A type of traditional medical expense coverage that provides substantial benefits for hospital surgical expenses and physicians' fees.

Managed care

A method of integrating the financing and delivery of health care within a system that seeks to manage the cost, accessibility and quality of care.

Maternity coverage

Many individual plans and some small-group plans for groups of fewer than 15 employees don't cover the costs associated with pregnancy and birth. However, federal law requires that group plans cover maternity if a group has 15 employees or more.

Member

The person whose life or health is insured under an insurance policy. Also referred to as the "insured."

Mental health - inpatient

Inpatient mental health care is generally reserved for severe mental health problems, such as schizophrenia and severe depression. State laws vary widely on the degree to which insurance companies must cover mental illness. Most plans do provide some coverage, though there may be limitations such as the severity or nature of the illness and the duration of care.

Mental health - outpatient

Outpatient mental health benefits are generally divided into two categories, severe and non-severe health care. State laws vary widely on the degree to which insurance companies must cover mental illness. Most plans do provide some coverage, though there may be limitations such as the severity or nature of the illness and the duration of care.

MSA -- benefits

The newest choice in health insurance for the self-employed, Medical Savings Accounts (MSAs) allow you to build up a tax-free savings account to pay for routine medical expenses.

You build the account with tax-free dollars, and they remain tax-free while your MSA is active. Your MSA is used in conjunction with a high-deductible insurance policy.

With the high-deductible insurance plan, the cost of an MSA can be kept competitively low. Tax-free dollars and an affordable price save you money.

N**Network**

A group of doctors, hospitals and other health-care providers contracting with a health plan, usually to provide care at special rates and to handle paperwork with the health plan.

Non-formulary drugs

Non-formulary drugs often require a higher copayment. Non-formulary drugs are those that have not yet been reviewed or have been denied formulary status, typically because they offer no extra benefit over the drugs already on a plan's formulary list.

Non-severe mental health

Non-severe mental health problems are generally psychologically-based, such as phobias, manias and mild-to-moderate depression. In most cases, these problems can be treated without a stay at a treatment facility.

O**Office visit**

Any time you visit a doctor at his or her office for medical care.

Out-of-network

Health care services received outside the HMO, POS or PPO network.

Out-of-pocket expense

Any medical care costs not covered by insurance, which must be paid by the insured.

Outpatient surgery

Surgery that does not involve an overnight stay in a hospital.

P**Physical therapy**

Not all plans cover physical therapy -- a program of special exercises that can help an injury heal without restricting movement or limiting function.

Point-of-service plan

An HMO plan that also incorporates an indemnity plan option allowing members to obtain medical care from providers outside of the HMO network at a reduced benefit and at greater out-of-pocket expense.

Policy

A written document that contains the terms of the contractual agreement between an insurance company and the owner of policy.

Policy year

The period of time that the policy is to remain in force.

Policyowner

The person or business that owns an insurance policy.

Portable coverage

Group insurance coverage that can be continued by an insured employee who leaves the covered group.

Pre-admission certification

A component of utilization review under which the utilization review organization determines whether an insured's proposed non-emergency hospital stay or some other type of care is most appropriate and what the length of an approved hospital stay may be.

Pre-existing condition

(1) According to most individual health insurance policies, an injury that occurred or a sickness that first appeared or manifested itself before the policy was issued and that was not disclosed on the application for insurance. (2) According to most group health insurance policies, a condition for which an individual received medical care during the three months immediately prior to the effective date of his coverage.

Pre-existing conditions provision

A health insurance policy provision stating that benefits will not be paid for any illness and/or condition that existed prior to one becoming an insured under the particular health plan in question, until the insured has been covered under the policy for a specified period.

Preferred provider organization (PPO)

An organization where providers are under contract to an insurance company or health plan to provide care at a discounted or negotiated rate. Typically, you can see any doctor in the PPO network without requiring special approval, and you usually do not need to choose a primary care physician. Most PPOs will also allow you to seek care outside of the PPO network; however, the benefits are usually reduced and the insured has a greater out-of-pocket expense.

Premium

A specified amount of money that the insurer receives in exchange for its promise to provide health insurance to an individual or a group.

Prescription drug coverage (Rx)

A type of specified expense coverage that provides benefits for the purchase of drugs and medicines prescribed by a physician and not available over-the-counter. Often a plan will provide a prescription drug card that allows the insured to obtain medications by simply paying a copay at a participating pharmacy.

Primary Care Physician (PCP)

A general or family practitioner who serves as the insured's personal physician and first contact with a managed care system. The PCP will usually direct the course of your treatment and/or refer you to other doctors and/or specialists in the network.

Probationary period

The length of time that a new group member must wait before becoming eligible to enroll in a group insurance plan.

Q**Quote**

The preliminary amount of premium the insured and/or group will pay per month before underwriting factors are considered.

R**Renewal date**

The specified date of when the health insurance coverage will renew for another period, typically one year.

Routine annual exam

A yearly medical "checkup," during which your doctor will perform simple medical care such as checking your height, weight, vision and blood pressure, as well as screening for problems like colon cancer, cervical cancer, prostate cancer and high cholesterol.

RX drug: formulary/non-formulary

Some plans divide all drugs into two categories: formulary or non-formulary. If you have drug coverage, your prescription (RX) copayment may be different for formulary and non-formulary drugs.\

S**Severe mental health**

As defined by the American Psychiatric Association in their Diagnostic and Statistical Manual (DSM), severe mental illness includes the following disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa. Such problems generally require at least occasional inpatient care.

Short-term disability

This type of coverage pays a percentage of your salary if you become temporarily disabled, meaning that you are not able to work for a short period of time due to sickness or injury (excluding on-the-job injuries, which are covered by workers compensation). The per-week amount is usually 50, 60 or 66 2/3 percent of your weekly salary, and lasts for a period of time specified by the plan.

Short-term medical coverage

Similar to flex-term medical coverage. Short-term medical coverage is a major medical plan designed to protect you in the event of an illness or injury during "gaps" in your traditional medical coverage -- when you are between jobs or plans, a recent graduate, on strike, etc. Short-term plans are not meant to cover routine exams and preventive care; if you are looking for a choice of plan types and the ability to renew your plan beyond one year, a traditional medical plan, while typically more expensive, may be a better fit for your health insurance needs.

Skilled nursing

A level of care for patients who need intensive, 24-hour nursing supervision. This can take place in the home or in skilled nursing facilities, which offer services such as rehabilitation and specialized nutrition.

Small-group plan

A health insurance plan that is specifically designed for employers with a number of employees under a specified amount.

Standard Industrial Classification (SIC)

The Standard Industrial Classification (SIC) system is a series of number codes that attempts to classify all business establishments by the types of products or services they make available. Establishments engaged in the same activity, whatever their size or type of ownership, are assigned the same SIC code. These definitions are important for standardization. Insurance companies use SIC codes to determine specific rates for various industries. HealthInsurance.com uses these codes to ensure that you receive the best possible rate for your occupation.

Standard risk rate

The risk category that is composed of proposed insureds who have a likelihood of loss that is not significantly greater than average.

Stop-loss provision

A major medical policy provision under which the insurer will pay 100 percent of the insured's eligible medical expenses after the insured has incurred a specified amount of out-of-pocket expenses in deductible and coinsurance payments.

Supplemental accident

This kind of coverage provides extra financial security for you and your family in the event of accidental death or dismemberment.

T**Term life insurance**

A type of life insurance that provides a death benefit if the insured dies during a specific period.

U

Underwriters

Insurance company employees who are responsible for identifying and classifying the degree of risk represented by a proposed insured.

Underwriting

The process of identifying and classifying the degree of risk represented by a proposed insured.

Urgent care

Urgent care is appropriate when a medical urgency arises which necessitates immediate care, but has not reached the level of extreme emergency. Most managed care plans require you to seek urgent care at a participating urgent care facility or hospital.

Usual, Customary and Reasonable fee

The maximum dollar amount of a covered expense that is considered eligible for reimbursement under a major medical policy.

V

Vision care coverage

A type of specified expense coverage that provides benefits for expenses the insured incurs in obtaining eye examinations and corrective lenses.

W

Well baby care

The goals of well baby care are 1) to immunize; 2) to provide parents with reassurance and counseling on safety, nutrition and behavioral problems; and 3) to identify and treat physical and developmental problems.

X

Sorry, we have no glossary items beginning with the letter "X".

Y

Sorry, we have no glossary items beginning with the letter "Y".

Z

Sorry, we have no glossary items beginning with the letter "Z".

Reprinted with permission from Kelsey National Corporation.