Health Insurance Glossary of Terms

Admitting Privileges: The ability of a doctor to admit a patient to a particular hospital.

Advocacy: Any activity done to help a person or group get something the person or group wants or needs.

Assignment of Benefits: When you assign benefits, you sign a document allowing your hospital or doctor to collect your health insurance benefits directly from your health carrier. Otherwise, you pay for the treatment and then the company reimburses you.

Assistive Technology Device: Any item, piece of equipment, or product system, whether acquired commercially off a shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of people with disabilities.

Association: A group of individuals or employers or combination thereof.

Basic Benefits Package: A defined set of health care services for which coverage must be available in each health insurance policy of plan.

Capitation: Capitation represents a set dollar limit that your health maintenance organization (HMO) pays to your primary care physician for providing medical treatment to you and your dependents. This fee is usually paid to the physician on a monthly basis. The physician gets no more or no less than this set fee no matter how much you use his or her services.

Care Coordination: Focuses on family needs and family satisfaction by providing an individual services plan for the family, negotiating for families, providing appropriate training and information for the family, and monitoring family needs across time.

Case Management: Case management is a system that insurance companies and HMOs use to ensure that individuals receive appropriate, timely, and reasonable health care services.

Chemical Dependency: A physical and psychological dependency to a mood- or mind-altering drug, such as alcohol or cocaine.

Claim: A request by an individual (or his or her health care provider) to an individual's insurance company for the insurance company to pay for services obtained from a health care professional.

Co-insurance: Co-insurance refers to money that an individual is required to pay for services, after a deductible has been paid. In some health plans, coinsurance is called a "co-payment." Co-insurance is often specified by a percentage. For example, the employee pays 20% toward the charges for a service and the employer or insurance company pays 80%.

Co-payment: Co-payment is a predetermined 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: Covered services are those medical procedures for which the insurer agrees to pay.

Deductible: The amount an individual must pay for health care services before insurance covers any of the costs. Deductibles are most frequently charged on an annual basis rather than on a per incident basis.

Denial of a Claim: Refusal by an insurance company to pay a claim submitted to them on behalf of an insured individual by a health care provider.

Employee Assistance Programs (EAPs): Mental health counseling services that are sometimes offered by insurance companies or employers. Typically, individuals or employers do not have to directly pay for services provided through an employee assistance program.

Exclusions and Limitations: Medical services that are either not covered or limited in benefit by an individual's insurance policy.

Guaranteed Issue: An insurance company or HMO will issue coverage to an applicant regardless of prior medical history.

Health Maintenance Organizations (HMOs): Health Maintenance Organizations represent "pre-paid" or "capitated" health care plans in which individuals pay small fees or co-payments for specified health care services over and above the monthly premiums paid to be a member of the HMO. Services are provided by physicians and allied health care personnel 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 an individual physician’s office. HMOs are available on both an individual and employer group basis.

Indemnity Health 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, Independent Practice Associations (IPAs) and Preferred Provider Organizations (PPOs). With indemnity plans, the individual pays a predetermined percentage of the cost of health care services and the insurance company pays the additional percentage ultimately adding up to 100% of charges. For example, an individual might pay 20% for services and the insurance company pays 80%. The fees for services are defined by the providers and vary from physician to physician. Indemnity health plans offer individuals the freedom to choose any physician or hospital.

Independent Practice Associations: A group of independent practicing physicians who band together for the purpose of contracting their services to HMOs, PPOs and insurance companies.

Long Term Care Policy: Insurance policies that cover the costs of providing nursing care, home health care services and custodial care for the aged and infirmed.

Managed Care: The system that HMOs, PPOs and indemnity plan uses to provide quality health care while controlling the costs of medical services that individuals receive.

Maximum Dollar Limit: The maximum amount of money that an insurance company will pay for claims within a specific period of time. For instance, most PPO types of programs have an overall lifetime maximum expressed in millions of dollars (usually a minimum of $1M). Maximum dollar limits vary greatly. They may be based on the type of illness or expressed in a period of time.

Medically Necessary: Many insurance policies will pay only for treatment that is deemed "medically necessary" to restore a person's health. For instance, many policies will not cover routine physical exams or plastic surgery for cosmetic purposes.

Out-Of-Plan: This phrase usually refers to physicians, hospitals or other health care providers who do not contract with the insurance plan (usually HMOs and PPOs). Depending upon the 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 Maximum: A predetermined limited amount of money that an individual must pay out of pocket, before an insurance company will pay 100% for an individual's health care expenses.

Pre-Admission Certification: Also called pre-certification review, or pre-admission review. This is approval by a case manager or insurance company representative for a person to be admitted to a hospital or inpatient facility in advance of their admission. Usually, the patient's physician requests that this process be completed. The goal of pre-admission certification is to ensure that individuals are not hospitalized for unnecessary surgical procedures or services that are not medically necessary.

Pre-Existing Medical Conditions: Any illness or health problem that existed prior to an individual obtaining medical coverage. Group health plans will cover pre-existing conditions after you have been covered for at least six months; individual plans after 12 months.

Preferred Provider Organizations (PPOs): This is a group of health care providers who have agreed by contract to furnish medical services to members of a health plan at discounted rates.

Premium: The amount you or your employer pays in exchange for insurance coverage.

Primary Care Physician (PCP): A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a "gatekeeper" for an individual's medical care, referring the individual to specialists and admitting them to hospitals when needed.

Reasonable and Customary Charges: The charges that a carrier determines normal for a particular medical procedure in a specific geographic area. If charges are higher than what the carrier considers normal, the carrier will not pay the full amount of charges and the balance is the responsibility of the insured.

Third-Party Payer: Any payer for health care services other than you. This can be an insurance company, an HMO, a PPO, or the Federal Government.

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

Waiver: A rider or amendment to a policy that restricts benefits by excluding certain medical conditions from coverage.

Additional Resource Information

Evaluating Managed Care Plans for Children with Special Health Needs: A Purchaser's Tool: http://policyweb.ichp.ufl.edu/ichp/purchaser/Default.htm

HealthPlan.net: http://www.healthplan.net/glossary.htm