

## Health Insurance Glossary

**advance care planning consultations:** A controversial provision of H.R. 3200 would have paid physicians to provide counseling to elderly or terminally ill patients who request the counseling. The provision – ultimately omitted from the passed health reform legislation – would have paid for one counseling session at least every five years, during which patients could discuss advance care planning, advance directives, living wills, palliative care and hospice and possible life-sustaining treatments for the terminally ill. Critics said the proposal would create “death panels” and described its intent as “guiding you in how to die.”

**beneficiary:** The beneficiary is the person who is named to receive proceeds from a life insurance policy or retirement plan in the event of the employee’s death.

**brand-name drug:** Prescription drugs marketed with a specific brand name by the company that manufactures it, usually the company which develops and patents it. When patents run out, generic versions of many popular drugs are marketed at lower cost by other companies. Check your insurance plan to see if coverage differs between name-brand and their generic twins.

**carrier:** The insurance company or HMO offering a health plan.

**certificate of insurance:** The certificate of insurance is a printed description of the benefits and coverage provisions forming the contract between the carrier and the customer. It discloses what is covered, what is not, and dollar limits.

**claim:** A claim is 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.

**claim:** A claim is an application for benefits provided by your health plan. You must file a claim before funds will be reimbursed to your medical provider. A claim may be denied based on the carrier’s assessment of the circumstance.

**COBRA:** COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985, federal legislation that allows you – if you work for an insured employer group of 20 or more employees – to continue to purchase health insurance for up to 18 months if you lose your job, or your employer-sponsored coverage is otherwise terminated. Related terms: employer-sponsored health insurance

**coinsurance:** Coinsurance 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 “copayment.” Coinsurance 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. Related terms: copayment, deductible

**copayment:** Copayment 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 copayment for each office visit, regardless of the type or level of services provided during the visit. Copayments are not usually specified by percentages. Related terms: co-insurance, deductible

**credit for prior coverage:** Credit for coverage may or may not apply when you switch employers or insurance plans. A pre-existing condition waiting period met under while you were under an employer’s (qualifying) coverage can be honored by your new plan, if any

interruption in the coverage between the two plans meets state guidelines.

**deductible:** The deductible is 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. Related terms: coinsurance, copayment

**denial of claim:** Denial of claim is the refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional.

**dependent:** A dependent is a person or persons relying on the policy holder for support may include the spouse and/or unmarried children (whether natural, adopted or step) of an insured.

**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.

**employer-sponsored health insurance:** Of Americans who have health coverage, nearly 60 percent secure that coverage through an employer-sponsored plan, often called group health insurance. Millions take advantage of the coverage for reasons as obvious as employer responsibility for a significant portion of the health care expenses. Group health plans are also guaranteed issue, meaning that a carrier must cover all applicants whose employment qualifies them for coverage. In addition, employer-sponsored plans typically are able to include a range of plan options from HMO and PPO plan to additional coverage such as dental, life, short- and long-term disability. Read more about group health insurance. Read recent

news articles about employer-sponsored health insurance.

**exclusion:** An exclusion is a provision within a health insurance policy that eliminates coverage for certain acts, property, types of damage or locations.

**generic drug:** Once a company's patent on a brand-name prescription drug has expired, other drug companies are allowed to sell the same drug under a generic label. Generic drugs are less expensive, and most prescription and health plans reward clients for choosing generic drugs.

**group health insurance:** Coverage through an employer or other entity that covers all individuals in the group. Read more about group health insurance.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA):** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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.

**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 the HMO, services may be provided in a central facility, or in a physician's own office (as with IPAs.)

**in-network:** In-network refers to providers or health care facilities that 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.

**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, 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.

**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 Certificate of Insurance.

**long-term disability insurance:** Pays an insured a percentage of their monthly earnings if they become disabled.

**Medicaid:** Medicaid is a health insurance program for low-income individuals who can not otherwise afford Medicare or other commercial health insurance plans. Medicaid is funded in part by the government and by the state where the enrollee lives.

**Medicare:** Medicare is the federal health insurance program created to provide health coverage for Americans aged 65 and older and later expanded to cover younger people who have permanent disabilities or who have been diagnosed with end-stage renal disease or amyotrophic lateral sclerosis (ALS).

**out-of-plan (out-of-network):** 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 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.

**Patient Protection and Affordable Care Act (PPACA):** The Patient Protection and Affordable Care Act (PPACA) – also known as the Affordable Care Act or ACA – is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010 and will “continue to be rolled out over the next four years.” Key provisions are intended to extend coverage to millions of uninsured Americans, to implement measures that will lower health care costs and improve system efficiency, and to eliminate industry practices that include rescission and denial of coverage due to pre-existing conditions.

**primary care provider (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.

**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.

**second opinion:** It is a medical opinion provided by a second physician or medical expert, when one physician provides a diagnosis or recommends surgery to an individual. Individuals are encouraged to obtain second opinions whenever a physician recommends surgery or presents an individual with a serious medical diagnosis.

**short-term disability:** An injury or illness that keeps a person from working for a short time. The definition of short-term disability (and the time period over which coverage extends) differs among insurance companies and employers. Short-term disability insurance coverage is designed to protect an individual’s full or partial wages during a time of injury or illness (that is not work-related) that would prohibit the individual from working.

**waiting period:** Waiting periods were among the fears vocalized by opponents of single-payer health care systems. Critics of single-payer systems in countries such as Canada cite lengthy waits for some elective surgeries. Proponents of single-payer systems note that a high percentage of Americans already are being unable to obtain medical care – including medication, testing and treatment – because of costs, while a much smaller percentage of residents in single-payer systems report that costs had limited their access to care.