Health Insurance Glossary

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A

Accredited (Accreditation)

A term typically applied to hospitals and other health care facilities, as well as certain health benefits plans, indicating that the facility or plan has met operating, quality and other standards established by a third party review agency.

Accumulation Period

Timeframe within a policy period in which deductible and out-of-pocket amounts are calculated. For most health insurance policies, the accumulation period is a calendar year.

Administrative Services Only (ASO)

An arrangement in which an employer hires a third party to deliver employee benefit administrative services to the employer. These services typically include health claims processing and billing. The employer bears the risk for health care expenses under an ASO plan.

Admitting Physician

The doctor responsible for admitting you to a hospital or other inpatient health facility.

Admitting Privileges

The right granted to a doctor to admit patients to a particular hospital.

Adjudication

The process used by health plans to determine the amount of benefit payment for a covered health care service. The term usually refers to the processing of a health care claim. The process includes a review of whether the service is covered by the health plan and whether deductibles, co-insurance, co-payments or other benefit limits apply.

Advanced (Advance) Directives

Sometimes called a "living will." An Advance Directive is a legal document that tells your physician what kind of care you want (and what kind of care you don't want) if you become ill and can't make medical decisions or communicate your decisions (for example, if you are in a coma). Hospital staff will routinely ask you if you have an Advance Directive when you are admitted to the hospital. Laws about Advance Directives vary in each state. You should be aware of the laws in your state. If you have an Advance Directive, be sure both your family and your physician have copies and are aware of your wishes.

After Care

The care or follow-up treatment needed by a patient who has recently undergone surgery, been involved in an accident or has experienced an illness requiring hospitalization.

Allowable Expense(s)

Also a "covered expense." Refers to amount of a charge for medically necessary health care that is "covered," or eligible to be paid by a health benefits plan.

Ambulatory Care

See Outpatient Care

Ancillary Services

Services, other than those provided by a physician or hospital, which are related to a patient's care, such as laboratory work, x-rays and anesthesia.

Appeal (Appeals process)

A process maintained by an employer or health plan that allows an individual to appeal an adverse benefit decision. If all or part of your claim is denied and you believe this decision is in error, you may use the appeals process to initiate an additional review of the claim. In some cases, your plan may not have had enough information to make a decision, and the appeals process gives you the opportunity to provide that information. To find out about your plan's appeals process, visit the health plan's website or call the toll-free number on your ID card.

Authorization

A health plan's process for approving payment for medical services covered by an individual's benefits plan. Depending on the plan, such authorization may be required before services are rendered (see Pre-authorization/Precertification).

B

Benefit

The term "benefit" may refer in general to a health plan (your "benefits"), specifically define the medical services covered under any particular health plan (a surgery "benefit") or refer to the payment received for services covered under the terms of the policy.

Benefit Maximum

See Lifetime Maximum

Benefit Period

The period during which benefits will be paid under a health benefits plan. This period is specified in your Certificate of Coverage or other plan document.

Board Certified

A physician who has passed examinations given by a medical specialty group and who has, as a result, been certified as a specialist in this area of practice.

Brand-name prescription drug

A medication protected by patent which cannot be dispensed without a prescription from a health care professional. In health insurance policies that include prescription drug coverage, there may be differences in the level of coverage for brand-name drugs versus generic drugs. Check your plan documents to know if brand-name drugs are covered under your policy, and, if so, whether they require a higher copayment or coinsurance.

Broker

A licensed legal representative of the policyholder, who negotiates with an insurance company on behalf of a customer, but is paid a commission by the insurance company.

C

Capitation

In some kinds of managed care plans, the health insurer pays physicians that participate in the network a fee called capitation. Generally, this is a fixed, prepaid amount that the provider receives as compensation for all services provided to a plan member.

Case management

A process of identifying individuals who have complex health care needs and coordinating the care they receive in an attempt to improve care outcomes.

Case Manager

A nurse, doctor, or social worker who arranges all services that are needed to give proper health care to a patient or group of patients.

Catastrophic Illness

A very serious and costly health problem that could be life threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause financial hardship.

Centers of Excellence

Hospitals that specialize in treating particular illnesses, or performing particular treatments, such as cancer or organ transplants.

Certificate of Coverage (Certificate of Insurance)

A description of the benefits, limitations and exclusions included in a health benefits plan. A copy of the Certificate of Coverage is generally provided when you enroll in a plan. Replacement copies can be obtained by contacting your plan directly, or in many cases through your employer.

Claim

Information submitted to a health plan to request payment for medical services provided to a person covered under that health plan.

Clinical Practice Guidelines

Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986)

A law that permits individuals to continue coverage temporarily under most employer health insurance plans when they would otherwise lose eligibility due to a loss of employment or a change in family status (such as divorce). The cost of this continued coverage is paid by the employee or dependent who elects it. Small employers, those with less than 20 employees, are generally not subject to COBRA.

Co-insurance

The portion of the cost of covered medical services paid by the patient under a health plan, after first meeting any applicable plan deductible. Co-insurance amounts, which are typically a percentage of the cost, may vary by type of service. Co-insurance requirements are specified in the plan documents.

Concurrent Review

Concurrent review involves monitoring the medical treatment and progress toward recovery, once a patient is admitted to a hospital, to assure timely delivery of services and to confirm the necessity of continued inpatient care. This monitoring is under the direction of medical professionals. Concurrent review is a component of "Utilization Review."

Consumer-directed health plan

Also referred to as "consumer-driven" or "consumer choice" health plans. A relatively new type of health plan designed to give consumers more control over a portion of their health benefit dollars, typically through a health fund or account that can be used to pay for covered medical expenses. Most health funds allow unused dollars to be rolled over from year to year, for as long as an individual is in the plan, and some plans allow the funds to go with you, even if you change jobs.

Contract Holder

An employer or individual who purchases a health benefits plan from a health insurer.

Contract Year

The period of time from the effective date of the contract to the expiration date of the contract. A contract year is typically 12 months long, but not necessarily from January 1 through December 31.

Covered Benefit (Covered Charges/Expenses)

See Allowable Expense

Conversion Option

An option that allows an individual who is leaving an employee health benefits plan to purchase individual coverage at a pre-determined rate. This is often an option to COBRA continuation. Conversion is only available under certain plans.

Coordination of Benefits (COB)

When an individual is covered under more than one health benefits plan, coverage is "coordinated" to avoid duplicate payments. Rules establish which plan will pay benefits first and allow for sharing of claims information between plans.

Co-payment (Co-pay)

A specified dollar amount or percentage a patient is required to contribute toward the cost of covered medical services under a health plan. Like co-insurance, co-payments generally are applied after the patient has met any applicable plan deductible. Co-payments may vary by type of service. Co-payment requirements are specified in the plan documents.

Cost Sharing

This occurs when the users of a health care plan share in the cost of medical care. Deductibles, coinsurance, and co-payments are examples of cost sharing.

Credentialing

A system for assessing the professional/clinical qualifications and record of a physician, health professional or health facility. This includes a review of relevant training, academic background, experience, licensure, board certification and/or accreditation to provide certain types of medical services. Most health plans credential physicians and facilities before adding them to their list of participating providers and periodically re-credential these providers while they remain in the network.

Critical Access Hospital

A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Custodial Care

Services provided to attend to an individual's daily living activities, which does not require trained medical personnel. Examples include assistance in walking, bathing, dressing, and feeding. Coverage for custodial care is not included in most basic health benefits plans, including Medicare; check your plan documents to see if it is covered under your plan. Custodial services typically ARE covered under long term care insurance, making this a valuable supplement to traditional health coverage.

Customary and Reasonable

"Usual, Customary and Reasonable (UCR)"

D

Deductible

A fixed amount that an individual must pay for covered medical services before the health plan will pay benefits.

Deductible Carry Over Credit

Charges applied to the deductible for services during the last 3 months of a calendar year which may be used to satisfy the following year’s deductible

Defined Contribution Plan

A pension, health or other benefits plan typically provided by an employer under which the employer gives each employee a fixed amount of money, or "contribution." When provided for health benefits, this amount can be used either to purchase health insurance or directly to pay for the cost of health services. There are distinct differences among the types of defined contribution plans offered from employer to employer. You should check with your employer for details if they offer these plans.

Dependent Care Reimbursement Account

These accounts let you set aside pre-tax dollars to pay for eligible childcare expenses. Because the reimbursement account contributions are not taxed, you decrease your taxable income while increasing your available cash. Funds do not roll over from year to year, are not portable and do not accrue interest.

Dependent

A child or spouse who gets health insurance coverage through your plan. Often times there are limits for enrolling a new dependent in a health plan, so check with your health plan provider if you are getting married, having a new baby or adopting a child. Also keep in mind that your child may no longer be covered under your health plan when he or she reaches a certain age.

Direct Access

Also called "open access." A term used to describe certain health benefits plans under which an individual may go directly to any participating provider in the health plan's network without a referral from a primary care physician.

Disease Management

A program for identifying individuals with a specific illness or disease (usually chronic in nature) and using an integrated health care approach to help prevent recurrence of symptoms, maintain a high quality of life and prevent future need for medical care. Individuals enrolled in a disease management program may receive educational information, supplies and follow-up contact with medical professionals to help them manage their illness.

Drug Formulary

See Formulary

Durable Medical Equipment

A piece of medical equipment, such as a wheelchair, that can be used repeatedly, primarily serves a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use at home. Other examples include hospital beds and oxygen equipment. It is important to note that some health benefits plans do not cover durable medical equipment as part of the basic plan. You should understand whether your benefits plan covers DME and, if not, evaluate whether you should purchase separate coverage.

E

Effective date

The date on which the coverage under a person's health plan goes into effect. Typically, the effective date of your coverage can be found on your ID card.

Eligible Dependent

A dependent of a covered person (spouse, child, or other dependent) who meets all requirements specified in the contract to qualify for coverage and for who premium payment is made

Eligible Expenses

The lower of the reasonable and customary charges or the agreed upon health services fee for health services and supplies covered under a health plan

Emergency

A serious medical condition resulting from injury or illness that arises suddenly and requires immediate medical attention.

Employee Assistance Program (EAP)

Programs that offer access to professional counselors who provide confidential assessment and short-term counseling to employees and their families. Counselors assist employees in dealing with various issues, including marriage and family problems, stress-related problems, financial and legal difficulties, and psychological and workplace conflict. The program often includes 24-hour phone access. Check with your employer to see if there is an EAP available to you.

Enrollee

A subscriber or dependent covered under a health plan, sometimes also referred to as a "member."

Exclusion

Specific conditions or circumstances that are not covered for benefits under a health plan. These are listed in detail in the plan's Certificate of Coverage (COC) or other plan document and sometimes described more generally in marketing or other plan materials. Check exclusions carefully before enrolling in a plan.

Experimental Services or Procedures

Also called "investigational." Health care services, supplies, treatments or drug therapies that have yet been determined to be effective and safe in treating the illness or injury for which their use is proposed.

Explanation of Benefits (EOB)

Under some health insurance plans, an Explanation of Benefits form is provided directly to the enrollee to explain how a health benefits claim was paid. In addition to claims payment information, the EOB often includes information on the appeals process. EOBs are sometimes mailed and are often now available through the Internet.

F

Fee for Service

A reimbursement system that pays physicians or other providers a fee for each service they perform, often based on a schedule of fees.

Flexible Spending Account (FSA)

A FSA is a tax-advantaged account established in connection with an employer-sponsored benefits plan that can be used to pay for medical expenses. Contributions to the FSA are typically made by the employee. The contributions are free of federal, Social Security and most state taxes. Funds must be used in the year they are accrued; unused funds revert to the employer. Funds are not portable and do not accrue interest.

Formulary

A list of covered prescription drugs established by a health plan with the assistance of their Pharmacy and Therapeutics Committee. Generally includes both brand-name and generic prescription drugs. Most health benefits plans that cover prescription drugs use a formulary and, within each category of covered drugs, may provide different levels of coverage based on the drug's cost, efficacy or other considerations. Formularies are subject to periodic review and modification by a health plan.

Fully Insured

An employer who pays a premium to a health plan provider to provide and administer benefits plans for its employees is said to be "fully insured." This means the insurer, not the employer, is liable for the cost of medical claims.

G

Gatekeeper

A primary care physician in a managed care environment who is responsible for managing the patient's overall care and who must authorize all specialist referrals. In most health maintenance organizations (HMOs), the secondary care is not covered by insurance if the primary care physician does not approve it.

Generic Prescription Drugs

A chemically equivalent version of a brand-name drug for which the patent has expired. Typically generic drugs are less expensive and are sold under the common name for the drug, not the brand name.

Group Coverage

Plans supported by an employer or employee organization that provide health coverage to employees as well as former employees and their families in many cases. Professional and alumni associations, such as local Chambers of Commerce, may also offer group health plans.

H

Health Care Consumerism

Health care consumerism is a movement that encourages individuals to become more involved in and take more responsibility for making smart health care decisions, managing their health benefits dollars and maintaining their overall health status.

Health Fund

A term applied to both Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) to describe a benefits account that can be used to pay for health care expenses.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is a federal law enacted in 1996, designed to improve availability, portability and efficiency of health coverage by

- Limiting exclusions for pre-existing conditions
- Providing credit for prior health coverage
- Allowing transmission of coverage information (i.e., covered family members and coverage period) to a new insurer
- Providing new rights to allow an individual to enroll for health coverage when he or she loses coverage or has a new dependent
- Prohibiting discrimination in enrollment/premiums
- Guaranteeing availability of health insurance coverage for small employers

HIPAA's Administrative Simplification and Privacy (AS&P) rules seek to improve the efficiency of the health care system by standardizing the electronic exchange of health information and protecting the security and privacy of consumer-identifiable health information.

Health Maintenance Organization (HMO)

A form of health benefits plan that provides or arranges for health services required by its members. In a traditional HMO plan non-emergency services must be received from a network of health care providers, although certain HMO plans may offer reduced benefits for care received outside of the network. In most HMO plans, members are required to select a primary care physician (PCP) from the network to provide routine care and make referrals for specialty and hospital services when appropriate.

Health Reimbursement Arrangement (HRA)

An HRA is an employer-paid benefit account offered to employees or retirees. HRA funds are generally available to pay for deductible and co-insurance amounts required under the health benefits plan provided by the employer, although some employers permit HRA dollars to be used for any qualified medical expenses. Unused funds in an HRA may be carried over from year to year, in accordance with rules defined by the employer.

Health Risk Assessment

A form or online tool that is filled out by an individual and used to assess the individual's current health status, as well as risk factors for future illness. It is a good idea to take a health risk assessment to understand your current health risks and ways in which you can reduce your risk for the future.

Health Savings Account (HSA)

An HSA is a tax-advantaged savings account that allows individuals to pay current health care costs or save for anticipated future expenses. To be eligible, an individual must be covered by a high-deductible health plan and not be eligible for coverage under any other health plan. Contributions to the HSA can be made by the employer, the employee or both. Contributions are tax deductible and earn interest tax free. The accounts are portable, meaning you can take them with you when you leave your employer. And balances accumulate from year to year. HSA funds can be used to pay for qualified medical expenses or withdrawn in cash, although cash withdrawals become taxable and may be subject to an additional withdrawal penalty.

High-Deductible Health Plan (HDHP)

A health benefits plan that meets the deductible and other benefit requirements to permit a covered individual to contribute to a Health Savings Account. Benefit requirements for a high-deductible health plan are established by Federal law. For 2007, the required annual deductible was at least $1,100 for individual coverage or $2,200 for family coverage; these minimums are adjusted annually for the cost of living. Premiums for high-deductible health plans are often lower than for other health plans, and the ability to fund a Health Savings Account is an attractive feature for many individuals. Before selecting one of these plans, however, you should check the total benefits and costs against your own experience and anticipated health needs.

HIPAA

See Health Insurance Portability and Accountability Act

Home Health Care

Skilled nursing or other therapeutic services provided in a home setting. Often home health care is covered as an alternative or follow-up to hospitalization or nursing home care. Check with your health plan on what services may be covered when provided in your home.

Hospice

A facility that provides supportive care at the end of life for individuals with terminal illnesses (such as cancer or AIDS).

Hospital pre-certification or pre-registration

Under some health plans, you need advance authorization before the plan will pay for certain medical services, such as going to the hospital. Check out your plan documents to see if there are any services that require preauthorization and whether you or your doctor needs to file the request.

I

ID Card

The identification card carried by a subscriber or dependent that provides important information relating to health coverage, such as the plan effective date, co-payments, etc. The card usually lists a toll-free number where patients or health care professionals may call for assistance with benefits. You should copy this phone number in another location in case you misplace your ID card.

In Network

Refers to care received from providers who participate in a health benefit plan's provider network, or network of participating physicians, hospitals and health care professionals. It's important to know if your physician is in network, since many health plans provide a higher level of coverage for doctors in their network. Some plans provide coverage only for emergency services received from providers not in their network. Plan materials on the plan website would probably provide a list of providers in their network.

Inpatient care

Health care service provided after a patient is admitted to the hospital.

Investigational Services

See Experimental Services

L

Length of Stay

The number of consecutive days a patient is hospitalized.

Lifetime Maximum

Some health benefits plans limit the total amount of benefits an individual may receive or limit the number of particular services an individual may receive over the term of the policy (for example, a plan may limit the total number of days of occupational therapy an individual may receive to 60, or have a maximum dollar amount of coverage over a lifetime). When enrolling in a plan, check your plan documents carefully to understand what, if any, lifetime maximum limits will be placed on your benefits.

Living Will

See Advance Directive

Long Term Care

A variety of personal care services designed to help people with prolonged or chronic physical illnesses, disabilities or cognitive impairment (such as Alzheimer's disease). Long term care services help people overcome limitations that keep them from being independent by providing ongoing assistance with day-to-day activities like bathing, dressing, eating or when supervision is necessary because of a cognitive impairment. Long term care services include care provided at home or in the community, including home health care and adult day care, as well as through assisted living facilities, nursing homes or other types of facilities. Long term care services can be expensive and are not covered to any substantial degree by medical plans, disability insurance or Medicare. Long term care insurance can help cover the cost of long term care services.

M

Mail-Order Pharmacy (Mail-Order Drugs)

Health benefits plans often offer distribution of prescribed medication directly to the patient through the mail. Since mail-order distributors can purchase drugs in larger volumes than retail outlets, the cost charged to patients is often lower. Your health plan may have lower pharmacy copayments if you use mail-order drug delivery. Check with your health plan to see if mail order is available to you.

Managed Care

Any form of health benefits plan that actively monitors health care services received by covered individuals for effectiveness, cost efficiency and/or quality. Typical managed care plans provide a higher level of benefits for a select network of contracted providers and may require preauthorization of certain services.

Mandated Benefits

Benefits that health care plans are required to provide by state or federal law.

Medicaid

A State government program that provides health care insurance for low income individuals, including families and children.

Medically Necessary

See Necessary

Medicare

A Federal government program that provides health care insurance to people aged 65 years or older, as well as certain disabled individuals. Medicare Part A provides benefits for hospital services and is provided to all eligible individuals without a required contribution. Medicare Part B covers physician and other outpatient services and is voluntary; eligible individuals are required to contribute to Part B coverage. See also Medicare Advantage and Medicare Prescription Drug Coverage.

Medicare Advantage

Medicare Advantage is a health benefits plan provided by a carrier as an alternative to traditional Medicare Part A and Part B coverage. Medicare Advantage plans may provide additional benefits and/or different levels of coverage and may have different required contributions compared to traditional Medicare coverage.

Medicare Advantage Plan (also called Medicare Part C)

A Medicare program that gives you more choices among health plans and extends benefits beyond the Original Medicare Plan. It includes private Medicare Advantage plans (such as HMOs and PPOs) that provide Part A and B benefits to enrollees, as well as Medicare prescription drug benefits beginning in 2006. Nearly everyone with Medicare Parts A and B is eligible for a Medicare Advantage plan. Medicare Advantage plans previously were called Medicare+Choice plans.

Medicare Part A

A government supported health insurance plan that helps cover inpatient hospital care, care in nursing homes, hospice care and some home health care for qualified Americans age 65 and older and certain younger individuals with disabilities. Most people pay for Part A coverage through taxes while working and, therefore, do not pay a deductible or monthly premium.

Medicare Part B

A government supported health insurance plan that covers doctors' services, outpatient hospital care, medical equipment, physical and occupational therapy and some home health care for qualified Americans age 65 and older and certain younger individuals with disabilities. Most people pay an annual deductible and a monthly premium for this health plan.

Medicare Part C (also called Medicare Advantage Plan)

A Medicare program that gives you more choices among health plans and extends benefits beyond the Original Medicare Plan. It includes private Medicare Advantage plans (such as HMOs and PPOs) that provide Part A and B benefits to enrollees, as well as Medicare prescription drug benefits beginning in 2006. Nearly everyone with Medicare Parts A and B is eligible for a Medicare Advantage plan. Medicare Advantage plans previously were called Medicare+Choice plans.

Medicare Part D

A government supported health insurance plan that helps cover prescription drug costs for qualified individuals who are entitled to Medicare Part A and/or B. Beginning January 1, 2006, private health insurance companies have offered these plans to Medicare recipients.

Medicare Prescription Drug Coverage

Sometimes called Medicare Part D coverage, a plan of benefits provided under the Medicare program that contributes to the cost of prescription drugs.

Medigap

Insurance that supplements the reimbursement provided by Medicare for medical services. Medigap plans often pay for certain classes of services not covered by traditional Medicare coverage, and may also pay for co-insurance or other amounts seniors are required to contribute to their Medicare coverage.

N

Necessary, Medically Necessary, Medically Necessary Services or Medical Necessity

Medical services or supplies that are appropriate and effective for the treatment of an illness or injury in accordance with clinical research findings or accepted medical standards, as described in the covered benefits section of individual plan documents. Health benefits plans typically pay only for services and supplies that are medically necessary.

Network

Also called "provider network." A panel of physicians, hospitals and other health care professionals who contract with a health benefits plan to provide services, typically at a negotiated rate of payment. With certain plans, an individual must access care from a network provider in order to receive the maximum level of benefits.

Non-participating Provider

This term is generally used to mean physicians, hospitals and other health care professionals who have not contracted with a health plan to provide services. Also called "non-preferred provider."

O

Open Access

See Direct Access

Open Enrollment

A period of time, often in the fall, when employees may make choices regarding their benefits for the following year. You should read enrollment materials carefully, since there are often substantial differences between health benefits plans.

Original Medicare Plan

See Medicare Part A and Medicare Part B.

Out-of-Pocket

Amounts such as copayments and deductibles that an individual is required to contribute toward the cost of health services covered by his or her health benefits plan. In some instances this term also includes amounts the individual pays for health services not covered by the plan. There are substantial differences between plans in the amount of out-of-pocket costs you may incur. If your benefits plan has high out-of-pocket costs, you might consider participating in a Flexible Spending Account or Health Savings Account, if one is available to you.

Out-of-Pocket Maximum

The limit on the amount an individual is required to pay for health care services covered by his or her benefits plan. Look for this information in insurance plan documents such as your Certificate of Coverage.

Outpatient Care

Care provided without overnight admission to a hospital or other medical facility.

Outpatient Surgery

Surgical procedures that do not require an overnight stay in a hospital or other medical facility. Such surgery can be performed in the hospital, a surgery center or physician's office.

Over-the-Counter (OTC) Drug

Medication that may be obtained without a prescription from a medical professional.

P

Participating Provider

A physician, hospital, nursing facility or other health care provider that has contracted with a health plan to provide covered services for a negotiated charge. Also called "preferred care provider."

Pension

A retirement fund for employees (usually tax exempt) paid for or contributed to by an employer as part of an employee's compensation package. Many employers are replacing pensions with 401(k) plans. Pension plans vary by employer so it's important to get details in writing, such as the contribution plan, choices for receiving benefits and an explanation about spousal rights to the pension.

Personal Health Record

A Personal Health Record (PHR) stores health-related information in a password-protected online record. In many cases information such as claims submitted to your health insurer, the location of your last doctors' visit and

prescribed treatment is automatically added by your insurer. Depending upon the PHR, individuals may have the opportunity to input personal information like family history of disease, blood type, diet and exercise regimens and allergies. The Privacy Rule, part of the Health Insurance Portability and Accountability Act (HIPAA), regulates how health information that can be linked to an individual may be used.

Pharmacy and Therapeutics (P&T) Committee

A group of physicians, pharmacists and other health care professionals who advise a health plan regarding prescription drug formularies and the safe and effective use of medications.

Plan Documents

Plan documents describe the details of a health plan - what services are covered, what services are not covered, and what charges the patient will be required to pay (copayments, deductibles, coinsurance). "Plan documents" may include a group agreement, group policy, Certificate of Coverage, Certificate of Insurance or Evidence of Coverage. You should read the plan documents before deciding which health plan is right for you. You may obtain a copy of the plan documents through your employer or health plan.

Practice Guidelines

Also called "clinical practice guidelines," "practice parameters" or "medical protocols." These guidelines describe optimal approaches to diagnosis and treatment of specified illnesses or injuries based on current medical research.

Preauthorization/Precertification

Under some health plans, individuals are required to receive advance authorization of particular medical services. Such advance authorization is called “preauthorization” or “precertification.” Depending on the type of plan you have, your physician may request this authorization or you may be required to do so. Check your plan documents to see if there are any services that require preauthorization under your plan and, if so, who is responsible for requesting it.

Pre-existing Condition

A health condition (other than a pregnancy) or medical problem that was diagnosed or treated prior to enrollment in a new health plan.

Preferred Care Provider

See Participating Provider

Preferred Provider Organization (PPO)

A health benefits plan that allows an individual to choose any provider without designating a primary care physician (PCP), but offers higher levels of coverage to those who choose participating or preferred physicians or hospitals.

Premium

The amount charged, often in installments, for an insurance policy. If you have health benefits through your employer, the cost of the premium is often shared between you and your employer. You should know what your employer is paying for your health premium, as this is part of your total compensation.

Prescription Drug

A medication that cannot be dispensed without an order from a medical professional. The term is used to distinguish from over-the-counter drugs, which can be obtained without a prescription.

Preventive Care

Programs or services that can help maintain good health (such as annual physical exams or immunizations) or are meant to detect early signs of disease (such as mammograms and colon cancer screenings). Check to see that these are covered under your health plan.

Primary Care Physician/Primary Care Provider (PCP)

A physician who is part of a health plan's network and serves as a patient's main point of contact for medical care. A PCP typically provides basic medical and coordinates and supervises other care received by the patient. A PCP is usually a general or family care practitioner, or in some cases, an internist, pediatrician or OB/GYN. PCPs provide patients with referrals for specialist care or other medical services. In some health plans, you must choose a PCP to coordinate your care.

Prior authorization

Review of need for health care items or services before services are rendered or products are provided. This refers to a decision made by the health plan to cover or not cover the charges before the services are provided.

Provider

A licensed health care facility, program, agency, physician or other health professional that delivers health care services.

Provider Network

See Network

Q

Qualified Medical Expense(s)

Federal tax law defines a "qualified medical expense" is for purposes of FSA, HRA, HSA and MSA spending. Expenditures from an FSA or HRA must be a qualified medical expense under this definition. HSA funds may be withdrawn for other purposes, but such withdrawals are taxable and may be subject to an additional tax penalty. The Federal definition, which is contained in Section 213(d) of the Internal Revenue Code, is relatively broad, including all services covered under most health benefits plans as well as certain services and supplies (such as eyeglasses) that generally are not covered by health plans. Complete details can be found in IRS Publication 502.

Qualifying Event

An occurrence (such as death, termination of employment, divorce, etc.) that changes an employee's eligibility status under a group health plan.

R

Reasonable Charge

A limit set by a health plan on the amount it will pay for a medical service. This limit is often determined by reference to amounts typically charged for a particular health care service by other providers in the same

geographic area, although some plans may refer to other payment standards (such as the amount paid by Medicare). Also called "usual, customary and reasonable (UCR)" or "customary and reasonable."

Referral

In some health plans, patients must receive a referral from their primary care physician (PCP) to receive covered services from a specialist or receive other health care services. A referral is a specific set of directions or instructions from a PCP, which direct an individual to a specialist or facility for medically necessary care. A referral may be written or electronic.

Reimbursement

Payment from a health benefits plan to reimburse an individual's covered medical expenses or directly to a health care professional in payment for services rendered to plan participants.

Renewal

A continuation of an insurance policy on revised terms, such as adjusted health insurance rates

Risk

For a health insurance company, risk is the chance of loss, the degree of probability of loss or the amount of possible loss. For an individual, risk represents such probabilities as the likelihood of surgical complications, medications' side effects, exposure to infection, or the chance of suffering a medical problem because of a lifestyle or other choice. For example, an individual increases his or her risk of getting cancer if he or she chooses to smoke cigarettes

S

Second Opinion

Visiting another physician or surgeon for an opinion regarding a diagnosis, course of treatment or specific types of elective surgery. Second opinions are generally voluntary, but may be required in certain instances under some health plans.

Section 213(d)

Section 213(d) of the Internal Revenue Code outlines what a "qualified medical expense" is for purposes of FSA, HRA, HSA and MSA spending. Expenditures from an FSA or HRA must be a qualified medical expense under this code section. HSA funds may be withdrawn for other purposes, but such withdrawals are taxable and may be subject to an additional tax penalty.

Self-Insured

Also called "self-funded." An employer who takes on the financial responsibility for paying the health benefits claims of its employees is said to be "self-insured" (versus a "fully insured" employer, who pays a health insurance company to take on financial responsibility for claims). Self-insured plans can be administered by the employer or an outside company.

Service Area

The geographic area in which a health plan is licensed to operate (where applicable) or, when licensing is not required, the geographic area where an adequate network is established to provide services covered under a benefits plan.

Skilled Nursing Facility

A licensed institution that provides regular medical care and treatment to sick and injured persons. Daily medical records are kept and patients are under the care of a licensed physician.

Social Security Retirement Benefits

A government supported retirement benefit program funded through a federal income tax and paid to Americans based on age, number of years worked and income earned over an individual's career. Higher lifetime earnings result in higher benefits, while time off and lower income years may result in lower benefit payments. Age 62 is the earliest possible retirement age for Social Security benefits, and full retirement age is determined by year of birth. Choosing to collect retirement benefits before you reach full retirement age results in permanently reduced benefits.

Specialist

A physician who provides medical care in a medical or surgical specialty or subspecialty (for example, dermatologist, oncologist, etc.).

Subscriber

The individual covered under an employer's group agreement or group insurance policy. If an employer makes family coverage available, the subscriber may enroll eligible dependents in the benefits plan.

T

Traditional Plan

See Fee for Service plan

U

Urgent Care

Services received for an unexpected illness or injury that is not life threatening but requires immediate outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering or severe pain.

Usual, Customary, Reasonable (UCR)

See Customary and Reasonable

W

Well Baby/Well Child Care

Routine care for generally healthy children up through age eight, including checkups, tests and immunizations.

Wellness Program

A health management program that incorporates disease prevention, medical self-care, and health promotion. Wellness programs focus on changing and/or reinforcing healthy lifestyle behaviors that can help prevent illness and disability.