

A

Acute Care — A level of health care that can be provided only in a hospital.

Adjudication — Determination of allowance on a claim based on type of coverage and use of benefits.

Allowable Charge — Refers to the maximum fee payable as third party reimbursement for a given service or procedure.

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B

Basic Coverage — This includes basic medical or surgical care and hospitalization, exclusive of major medical coverage.

Benefit Days — The number of days for which a subscriber may receive benefits during a period of illness.

Benefit Period — The period of time for which payments for covered services are available. A period begins, for example, when a patient is admitted to a hospital and ends when at least 90 days have passed during which the patient has not been confined in any hospital or similar institution.

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C

Coinsurance — The portion of the cost for covered services which is the responsibility of the subscriber. In most cases the benefit program will pay 80% and the subscriber is responsible for 20% of the allowance for any given service. This arrangement is after any applicable deductible amount is met.

Commercial Carrier — Usually a for-profit insurance company which competes with Plans for health insurance business.

Community Rating — A method of establishing premium rates for small groups (50 members and below) and direct pay or non-group subscribers. The intent is to spread the risk evenly among all subscribers in the pool.

Contract — A legal agreement between the Plan and subscribers citing benefits, limitations and exclusions which determine responsibilities of both parties.

Conversion Option — The right of a group member, when leaving the group, to obtain direct payment coverage, without proof of insurability, similar to the coverage provided by the group.

Coordination of Benefits (COB) — Provisions and procedures used by insurers to avoid duplicate payments for subscribers and families insured under more than one group policy. COB attempts to ensure that subscribers receive all benefits they are entitled to without profiting from illness or injury.

Cost Sharing — Provisions of health insurance contracts that require the subscriber to share a portion of the costs of covered benefits. These usually include deductibles and co-insurance features with established out-of-pocket maximums each subscriber would be responsible for. Beyond these maximum amounts the contract generally pays 100% with no out-of-pocket responsibility on the part of the subscriber.

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D

Deductible — The amount the subscriber must pay for covered services before the insurer assumes liability for all or part of the remaining costs for covered services.

Designee — An individual that you designate in writing to represent you.

Direct Pay — Subscribers who are billed individually and pay premiums directly to the Plan. Frequently these subscribers are referred to as non-group members.

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Eligibility — The right to receive benefits based on the type of contracts held. Eligibility for local group, direct and Medicare Extended subscribers is determined locally. National Accounts' eligibility is determined through the central certification process and the Social Security Administration determines it for the federal Medicare program.

Enrollment — The procedure by which individuals or groups become subscribers. Total membership is referred to as total enrollment.

Exclusions — Contract provisions which cite situations, conditions or treatments that are not covered.

Experience Rating — A method of determining premiums based on the cost and use of benefits for specific groups. Generally groups having 51 or more subscribers are experience-rated.

Explanation of Benefits (EOB) — A statement sent to the subscriber explaining action taken by the Plan regarding a claim filed on his or her behalf.

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F

Fee for Service — An arrangement under which patients pay doctors, hospital or other health-care providers for each service rendered. Most then seek reimbursement from a private insurer or the government.

Fee Schedule — A listing of established allowances for specific procedures. It usually represents either standard or maximum amounts the insurer pays.

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G

Group Coverage — An insurance plan by which a number of employees or other group members and their dependents are insured under a single policy or contract.

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Health Maintenance Organization (HMO) — An organized system for providing health care in a geographic area that assures delivery of basic and supplemental health maintenance and treatment services to a voluntarily enrolled group of people for a predetermined, fixed prepayment fee. As a member of a Health Maintenance Organization or HMO, you must receive all your care from a panel of participating physicians, consultants and facilities. This panel is sometimes referred to as participating providers or as a participating network. To receive your benefits, all services need to be provided within the participating panel and rendered by or referred by your primary physician ("PCP").

Home Health Care — Nursing, physical, occupational and speech therapy given at a patient's home.

Hospice Care — A program providing palliative and supportive care for terminally ill patients and their families.

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I

Indemnity Benefits — Established dollar allowances for covered services. Payments are made toward the charge, not necessarily as payment in full.

In-Network Benefits — covered services that are provided, rendered or referred by a participating physician.

Inpatient — An individual who occupies a hospital bed while receiving hospital care. Services include room, board and general nursing care.(Typically more than 24 hours)

Intermediary — An organization selected to process and pay claims for provider services based on directives and guidelines issued by the sponsoring or authorizing organization-usually the federal (Medicare) or state (Medicaid) government.

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M

Managed Care — A popular term used by many to denote intercession in a patient's care by a third party to accomplish cost savings goals. For example, an insured group might insist on second surgical opinion or prior approval before surgery.

Master/Major Medical — Benefit programs designed to help offset high costs of catastrophic or prolonged illness or injury. Most of these programs incorporate deductibles and lifetime maximum amounts.

Medicaid — The medical assistance program for the indigent enacted by Congress in 1965. The program is the responsibility of the states which share the costs with the federal government.

Medicare — The federal health insurance program for persons 65 years of age or those under 65 who are totally disabled as determined by the Social Security Administration. Part A provides coverage for hospital inpatient services. Part B refers to medical-surgical services.

Membership — Includes any person covered by a subscriber contract or certificate.

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National Account — A benefit program designed to provide uniform coverage to an organization which has members in more than one Plan area.

Non-Participating Provider — A provider who does not participate with the insurance carrier.

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O

Open Enrollment — The period of time when new subscribers may choose or be permitted to enroll in health insurance programs.

Other Party Liability — See Coordination of Benefits (COB).

Out-of-Network Benefits — Covered services that are not provided, rendered, or referred by a participating provider.

Out-of-pocket expenses — Amount of money a member must pay for receipt of health services, as stated in the contract.

Outpatient — An individual receiving hospital care but not occupying a hospital bed as an inpatient. (Typically less than 24 hours)

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P

Participating Provider — A provider who participates with the insurance carrier.

Point of Service (POS) — This plan is a managed care program that has two components: in-network benefits and out-of-network benefits. You receive the highest level of coverage when you receive in-network benefits. When you receive out-of-network benefits, you will incur higher out-of-pocket expenses. You will be responsible for meeting an annual deductible before services are reimbursed and paying a fixed percentage coinsurance amount or co-payment for out-of-network services. You may also need to pay the difference between the insurance carriers and the actual charges for the services received.

Physician Hospital Organization (PHO) — An integrated health care delivery system with one or more hospitals entering a joint venture arrangement with one or more physician groups. The PHO maintains managed care contracts for inpatient as well as physician services.

Pre-existing Condition — Any illness, injury or condition existing prior to the effective date of a health insurance contract.

Preferred Provider Organization — An arrangement under which an insurance company or employer negotiates discounted fees with networks of health-care providers in return for guaranteeing a certain volume of patients. Enrollees in a PPO can elect to receive treatment outside the network but have to pay higher co-payments or deductibles for it.

Primary Care Physician (PCP) — Your PCP is your partner in managing and coordinating your health care services. If you are a member of an HMO plan, your PCP is responsible for coordinating all of your medical care, including diagnosis, treatment, referrals to specialists, hospitalization, and follow-up care. He or she works with a team of health care professionals, which may include physician assistants and nurse practitioners, to provide your treatment. Your PCP may be certified in internal medicine, family practice, general practice, or pediatrics. Women may also choose a gynecologist/obstetrician as their secondary PCP.

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Reciprocity — A national program to provide Plans with the ability to cover benefits for subscribers outside their home Plan area.

Rider — A document which modifies coverage of a contract either by expanding or diminishing benefits.

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S

Self-Insurance — The practice of a group, employer or association assuming complete financial responsibility for health insurance losses incurred by the membership.

Service Benefits — The provision of benefits without additional charges to the patient for services covered by the contract (paid-in-full coverage).

Skilled Nursing Facility — An organization with a medical staff and professional nursing services which provides comprehensive inpatient care usually for short periods and serves convalescent patients not acutely ill.

Specialist — A physician or health care professional, not the primary care physician, who is certified to practice in a specified field of medicine (for example, a cardiologist).

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T

Third Party Administrators(TPA) — Organizations hired to provide certain administration services to group benefit plans. Their functions may include premium accounting, claims review and payment, utilization reviews and other services. TPA's are most commonly employed by self funded groups.

Treatment Plan — Documentation of health services, such as rehabilitation services or restorative care, necessary to improve a member's health, based on the provider's evaluation and progress of the member.

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U

Usual, Customary, and Reasonable (UCR) — Health insurance programs that pay the physician's full charge provided that charge (1) does not exceed his or her usual fee, (2) does not exceed the amount customarily charged in that area for the same service and (3) is otherwise reasonable.

Utilization Review — An evaluation of the necessity, appropriateness and efficacy of the use of medical or institutional services.

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W

Waiting Period — time between the effective date of a contract and the date the Plan will assume liability for certain services — frequently in regard to pre-existing conditions.

Workers' Compensation — Coverage available from federal or state compensation acts for expenses resulting from job-related illness or injury.