Health & Benefits Glossary of Terms

Actual Charge

The amount a physician or supplier actually bills for a particular medical services or supply.

Administrative Services Only (ASO)

A type of contract with an insurance company or a third-party administrator that provides an employer with administrative services. It does not provide coverage for risk of insurance protection. The usual expenses covered include claims processing, plan design advice and printing benefit booklets.

Ambulatory Care

Medical services provided on an outpatient (non-hospitalized) basis. Services may include diagnosis, treatment, surgery, and rehabilitation.

Ancillary Services

Health care services conducted by providers other than physicians and surgeons. These may include such services as physical therapy and home health care.

Assignment of Benefits

When the insured authorizes the insurer or claims payer to pay benefits directly to the medical care provider.

Authorizations

Consent or endorsement by a primary care physician for patient referral to ancillary services and specialists.

Beneficiary

The person entitled to receive benefits under a plan, including the covered employee and his or her dependents.

Benefit

Amount an insurance company pays to a claimant, assignee, or beneficiary when the insured suffers a loss covered by the policy.

Benefit Package

All the services covered by a your benefits program which may include Medical, Dental, Vision, Life Insurance, Long Term Disability, Short Time Disability and any pre-tax accounts.

Benefit Period

The period of time benefits will be paid prior to which a new deductible for benefits must be satisfied.

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Benefit Schedule

A schedule that classifies employees who are eligible for coverage under a benefit plan and specifies the amount of coverage that is provided to the members of each class.

Benefit Statement

A personalized statement that specifies the benefit plans for which an employee is eligible and explains what benefits are available to that particular employee and his or her family. This statement is usually given to employees on an annual basis.

Cafeteria Plan

A plan which offers a choice between two or more benefits, or a choice between cash and one or more qualified benefits, and which complies with Section 125 of the Internal Revenue Code. (Also known as flexible benefit plans or "flex" plans).

Capitation

Method of compensation, used primarily by HMOs, to pay providers a fixed amount for each enrollee regardless of the actual number or nature of services provided to each person.

Carry-Over Provision

A provision found in many health plans which permits expenses arising out of claims that occur in the last three months of the year to carry over into the next year, without incurring new deductibles or coinsurance.

Claim

Demand to the insurer by an insured person for the payment of benefits under a policy.

Co-Insurance

The allocated percentage of cost of a covered service shared by the insurance company and the insured member generally after the deductible is satisfied. Some examples: Benefit Summary shows 80/20 – 80% of the negotiated rate will be paid by the insurance carrier and 20% will be paid by the insured member.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

A federal law that requires most employers to allow eligible employees and their beneficiaries to continue to self-pay for their coverage after it terminates for up to 18, 24, 29 or 36 months.

Community-Rated

Method of developing group-specific capitation rates by a health plan that generally does not account for unique characteristics of the group. The rate is based on the total experience of a given geographic area or "community."

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Consumer-Driven Health Plan (CDHP)

A health plan that features significant cost sharing inclusive of a high deductible and coinsurance to drive consumer awareness of the cost of healthcare, may or may not be coupled with an HRA or an HSA.

Contributory Plan

An employee benefit plan in which participants pay a portion of their coverage and the employers pay a portion. Example: The family rate is $200. The employer contributes $100 and the employee contributes the remaining $100 through payroll deductions.

Coordination of Benefits (COB)

A contractual provision to prevent an insured from receiving benefits under more than one health insurance plan so that the insured's benefits from all sources do not exceed allowable medical expenses or eliminate appropriate patient incentives to contain cost.

Copayment

A fixed dollar amount the member is responsible for when a medical service is received. The insurer is responsible for the rest of the reimbursement.

Cost Containment

Efforts or activities designed to reduce or slow down the cost increases of medical care services.

Cost Sharing

The sharing of costs between the payment of premium and medical expenses by the health care plan and its insured through employee contributions, deductibles, co-insurance and co-payments.

Coverage

The different types of options selected and the benefits paid under a plan or insurance contract.

Deductible

A fixed dollar amount that an insured person and/or family pays before the insurer starts to make payments for covered medical services. This may be isolated to select benefits such as hospitalization. Plans may have both per individual and family deductibles.

Dependent

Most commonly defined under group medical to include the employee’s spouse and unmarried dependent children (including stepchildren and adopted children).

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Dual Choice/Dual Option

An arrangement where an employer will offer an alternative in addition to its original health plan.

Durable Medical Equipment (DME)

Medically necessary equipment that can be used repeatedly. Example: wheelchairs, respirators, etc.

Eligibility Period

As an employee becomes eligible for company benefits, they are given a limited period of time to decide which benefits to subscribe to without having to go through physical examinations and prove insurability.

Eligible Employees

Must typically work between 20-30 hours per week, be compensated, and receive a W2.

Eligible Expense(s)

The portion of the medical care provider's services that are covered for payment under the terms of the health plan or insurance contract.

Employee Assistance Program (EAP)

An optional employer provided program to assist employees with certain personal issues. Benefits may include treatment for alcohol or drug abuse, counseling for mental and marital problems, referral for child care or eldercare, and crisis intervention.

Employee Participation

The number of employees that must enroll for the group benefits offered by that carrier. (See Participation)

Employer Contributions

The amount of premium the employer contributes for the employee. Example: The employee only rate is $150. The employer pays $112.50 for every employee enrolling in the plan. The balance of $37.50 would be paid by the employee.

Exclusion

Specific conditions or services that are not covered by the terms of the plan or insurance contract.

Exclusive Provider Organization (EPO)

Arrangement consisting of a group of providers who have a contract with an insurer, employer, third-party administrator, or other sponsoring group. Criteria for provider participation may be the same as those in PPOs but have more restrictive provider selection and credentialing process or otherwise forfeit reimbursement altogether.

Health & Benefits Glossary of Terms

Experience

Refers to the history of actual claims paid for the contract period (see Paid Claims) or can refer to the history of claims incurred during a contract period.

Explanation of Benefits (EOB)

A document sent to an insured when the plan or insurance company handles a claim. The document explains how reimbursement was made, or why the claim was not paid, and if any additional information is needed.

Extended Benefits

Benefits that continue, or become payable, after the termination of coverage from a plan or insurance contract, for example a hospitalization that continues after coverage would normally cease.

Family and Medical Leave Act (FMLA)

A federal law that requires employers with more than 50 employees to allow employees to take up to 12 weeks of unpaid leave in any 12 month period, for the birth or adoption of a child; care for a child, spouse or parent with a serious health condition; or for the employee's own serious health condition that makes it impossible to perform his or her job. The employee must be allowed to return to an equivalent job and health care benefits must be continued during the period of the leave.

Family Deductible

A provision in a major medical plan that waives future deductibles for all family members once a specified aggregate dollar amount of medical expenses has been incurred or after a specified number of family members have satisfied their individual deductibles.

Fee Schedule

Maximum dollar or unit allowances for health services that apply under a specific contract. Such schedules are used for surgical expenses, dental, vision and PPO fee plans.

Fee-for-Service Reimbursement

Payment for services based on each visit or service rendered. Under this arrangement plans or insurers have not established contracted or capitated rates of payments with providers prior to the insured claim occurrence.

First Dollar Coverage

Insurance coverages or benefits that pay the entire covered amount without subtraction of or use of a deductible.

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Flat Benefit Schedule

Benefit schedule under which the same amount of coverage is provided for all employees regardless of position or salary.

Flexible Spending Accounts (FSA)

Special accounts typically funded by an employee's salary reduction to help pay certain expenses not covered by the employer's plan or insurance contract. The advantage of these accounts is that after-tax dollars are converted to before-tax dollars, thereby reducing the actual cost of expenses.

Formulary

List of preferred pharmaceutical products to be used by a managed care plan's network physicians. Formularies are based on evaluations of the efficacy, safety, and cost effectiveness.

Fully Insured Plan

The employer pays the entire premium and, in return, transfers all of the risk and responsibility for claims payments to the insurance company.

General Agent

Licensed brokerage firm that has negotiated special arrangements with carriers for quoting multiple carrier plans and rates as well as offering a variety of other services.

Generic Drugs

A generic drug is equivalent to a brand name drug in active ingredients, dosage form strength quality, and intended uses, but produced and/or purchased at a lower cost.

Global Fees

Negotiated fees that are all-inclusive (one fee is paid for the entire range of services provided for a specific episode or episode of care.)

Grace Period

A time period that follows the premium due date when the coverage and policy remain in force.

Health Maintenance Organization (HMO)

An organization that provides a wide range of comprehensive health care services for a specified group of enrollees for a fixed, pre-paid premium. There are several models of HMOs: Group Model, Individual Practice Association (IPA), Staff Model and Network Model.

Health & Benefits Glossary of Terms

HIPAA--Health Insurance Portability and Accountability Act of 1996

A federal law that affects how confidential information is collected, used and shared. It has created new standards for insurers who must now take more precautions to protect the private information of their customers. The Act has also created constraints to the industry's ability to access medical records related to investigating claims-related injuries.

HRA--Health Reimbursement Arrangement

Employer funded medical expense reimbursement plan for qualifying medical expenses.

HSA--Health Savings Account

Employer/Employee funded medical expense reimbursement plan for qualifying medical expenses. The plan is held in the employee's name and requires a high deductible health plan and qualified custodian.

Hospital Expense Benefits

Benefits provided under a medical expense plan for hospital charges incurred. Benefits are for room and board and other charges for certain services and supplies ordered by a physician during a person's hospital confinement.

Hospital Indemnity Insurance

Hospital indemnity coverage is insurance that pays a fixed cash amount for each day you are hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount.

In-Network

A group of doctors, hospitals and other health care providers that have contracts with an insurance company to provide care are special agreed upon rates.

Indemnity Insurance

Health care insurance plan providing benefits in a predetermined amount for covered services. Traditionally, the insurer pays on a fee-for-service basis with no involvement in the actual delivery of health care services.

Individual or Independent Practice Association (IPA)

Association of individual physicians that provides services on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service basis. It is one model of HMO managed care. IPAs may also serve non-HMO patients.

Ineligible Employees

These employees typically are temporary, seasonal, leased or are compensated on a 1099 basis.

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Initial Deductible

A deductible that must be satisfied before any benefits are paid under the medical expense plan.

Lapse

Termination of insurance coverage for failure to pay premiums.

Lifetime Aggregate or Maximum

The maximum benefit payment provided under a plan or insurance contract.

Managed Care

Term used to describe the coordination of financing and provision of health care to produce high-quality health care for the lowest possible cost. A system that imposes control on the utilization of medical services and the providers who render the care. Managed care is provided through managed indemnity plans; Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), Health Maintenance Organizations (HMOs), or any other cost management environment.

Mandate

A specific procedure or coverage that a plan or insurance contract must offer dictated by state or federal law.

Mandated Benefits

Health care coverage required by state and federal law to be included in health insurance contracts.

Manual Premium Rate

The rate that is quoted in an insurance company's rate book.

Manual Rating

The process of determining a premium rate on the basis of broad classes of group insurance business, rather than on a particular group's claims.

Master Contract/Policy

A contract issued to someone other than the person insured that provides benefits to a group of individuals who have a specific relationship to the policy owner.

Medical Necessity

Term used by insurers to describe medical treatment that is appropriate and in accordance with generally accepted standards of medical practice.

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Medical Screening Program

A wellness program designed to discover and treat medical conditions before they become severe and result in a large medical expense, disability, or death claims. Common examples are screening for cholesterol, high blood pressure, diabetes, and breast cancer.

Mental Health Parity Act

Federal legislation that requires annual and lifetime dollar limits on mental health benefits to be on par with limits that apply to other medical conditions. The act applies to employers with more than 50 employees.

Mental Health Services

Behavioral health care services that may be provided on an inpatient, outpatient, or partial hospitalization basis.

Member/Enrollee

An insured person in the health plan.

Multi-Specialty Group Practice

Independent physicians' group that is organized to contract with a managed care plan to provide medical services to enrollees. The physicians are not employees of the HMO, but are employed by the group practice.

Multiple Option Plan

A single medical expense contract that combines two or more medical plans such as offering an HMO and PPO plans to employees.

Negotiated Fees

Managed care plans and providers mutually agree on set fees for each service. This negotiated rate is usually based on services defined by the Current Procedural Terminology (CPT) codes, generally at a discount from what the provider would usually charge. Once agreed to, providers cannot charge more than this fee.

Network Providers

Limited grouping or panels of providers in a managed care arrangement with several delivery points. Enrollees may be required to use only network providers or may have financing liability for using non-network providers for medical services.

Non-Contributory Plan

An employee benefit plan under which the employer pays the entire cost of the coverage.

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Non-Network Providers

Non-contracted or unapproved health providers who are outside a managed care arrangement.

Number of Lives

In small group, this is typically the number of employees. In large groups if it pertains to the group's experience, it could also include dependents.

Open-Ended HMO

A hybrid HMO product that allows members to use physicians outside the plan in exchange for additional financial liability in the form of a deductible, coinsurance, or co-payment.

Open Panel

A right included in an HMO which allows the covered person to obtain non-emergency covered services from a specialist without a referral from the primary care physician or gatekeeper.

Out-of-Network Coverage

Coverage that provides access to providers who do not contract with the health plan directly. There may be additional costs for seeing these providers as coverage is limited to an average rate in a geographic area that is set by an independent third party resource. Health plans that provide out-of-network access are designated as Point-of-Service (POS) or Preferred Provider Organizations (PPO). If your plan does not offer out-of-network coverage you may be required to pay all expenses.

Out-of-Pocket Expenses

Those health care costs that must be borne by the insured.

Out-of-Pocket Maximum

The maximum dollar amount an insured member is required to pay out of pocket during a year for covered medical expenses. Until this maximum is met, the plan and insured member shares in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, up to a lifetime maximum.

Participating Provider

A provider who has agreed to contract with a managed care program to provide eligible services to covered persons.

PEO (Professional Employer Organization)

A commercial firm that contracts with employers, allowing employers to outsource functions such as employee benefits, human resources and payroll, reducing their payroll and operating expenses.

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Per-Cause Deductible

A deductible amount that must be satisfied for each separate accident or illness before benefits are paid.

Point of Service Plans (POS)

Combination of HMO and PPO features. They provide a comprehensive set of health benefits and offer a full range of health services much the same as the HMO. However, the member does not have to choose how to receive services until they need them. The member can then opt to use the defined managed care program, or can go out-of-plan for services but pay the difference for non-plan benefits (e.g. 100 percent coverage for managed care Vs. 80 percent coverage out-of-plan).

Portability

Provides access to continuous health insurance coverage so the insured does not lose coverage due to any change in health or personal status (such as employment, marriage, or divorce).

Pre-Authorization

Previous approval required for referral to a specialist or non-emergency health care services.

Pre-Certification

Utilization management program that requires the individual or provider to notify the insurer before hospitalization or surgical procedure. Notification allows the insurer to authorize payment and to recommend alternate courses of action.

Pre-Existing Condition

A condition or diagnosis that existed (or for which treatment was received) before.

Preferred Provider Organization (PPO)

Managed care arrangement consisting of a group of hospitals, physicians, and other providers who have contracts with an insurer, employer, third-party administrator, or other sponsoring group to provide health care services to covered persons in exchange for prompt payment and increased patient volume.

Premium

Monthly cost to have insurance coverage set at plan inception for an annual term. These can only be changed if there is a significant change in the employee population. Employers are Premiums can be paid by employers, unions, employees, or shared by both the insured individual and the plan sponsor.

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Prevailing Charges

Amounts charged by health care providers that are consistent with charges from similar providers for identical or similar services in a given locale.

Preventive Medicine

Wellness and health promotion services that are part of the basic benefits package of a managed health care plan.

Primary Care

Non-specialist, basic routine medical care provided by family physician.

Primary Care Physician (PCP)

Primary deliverers and managers of health care, central to controlling costs and utilization. The PCP provides basic care to the enrollee, initiates referrals to a specialist, and provides follow-up care. Usually defined as a physician practicing in such areas as internal medicine, family practice, and pediatrics.

Probationary or Waiting Period

A period of time that must be satisfied before an employee is eligible for benefits under a group health plan.

Providers

Term used to describe medical professionals and services organizations that provide health care services.

Qualified Provider

Health care provider who has been contracted with, or authorized to provide, reimbursable health care services from an insurer or payer.

Qualifying Event

Certain types of events that would cause (except for COBRA continuation coverage), an individual to lose group health coverage. Example death of the covered employee, voluntary or involuntary termination of employment for reasons other than gross misconduct, reduction in the number of hours worked by the covered employee, divorce or legal separation, loss of dependent child status under the plan rules.

Reasonable and Customary

The maximum amount a plan or insurance contract will consider eligible for reimbursement, based upon prevailing fees in a geographic area.

Referral

Primary care physician-directed transfer of a patient to a specialty physician or specialty care.

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Riders

Benefits that are not included in the core medical plan, but can be purchased for an additional premium. (Ex. chiropractic coverage)

Self-Funding

An arrangement under which all or some of the risk associated with providing coverage is not covered by an insurance contract.

Self-Insurers

Employers, businesses, and other entities that chose to assume the responsibilities of an insurance company to insure their beneficiaries.

Self-Referral

Choice by the insured or patient of medical specialists or specialty services without need for primary care physician or health plan controls.

Specialty Physicians

Those physicians practicing in areas other than internal medicine, family practice, or pediatrics.

Summary Proposal

Summary of rates and benefits.

Trend Factor

The percentage of increase used by an insurance company or plan to reflect the projected rise in health care costs. Calculation factors also include inflation, utilization, technology and geographic area.

Unbundling

To increase the reimbursement paid by a plan or insurance contract, each medical procedure is billed under a separate code as a separate item, instead of part of one overall procedure.

Underwriters

Insurance professionals who determine if and on what basis an insurer will accept an application for insurance.

Usual, Customary, and Reasonable (UCR) Fees

Charges of health care providers that are consistent with charges from similar providers for identical or similar services in a given locale.

Health & Benefits Glossary of Terms

Vendors

Term describing a person, persons, groups, and organizations providing health care services for reimbursement.

Voluntary Benefits

A plan offered to employees under which they may purchase individual insurance coverage with premiums paid through payroll deductions by the employer; but the employer is not obligated to pay any portion of the premiums.

Waiting Period

Date of hire and the employee's eligibility to qualify for a plan of insurance or if already insured that time period before one is eligible for benefits (i.e. elimination period).

Waiver of Premium Provision

A provision in group insurance plans under which coverage is continued without the payment of premiums as long as an employee is totally disabled.

Wellness Programs

An employer provided program to promote the wellbeing of employees and their dependents. These programs are designed to treat medical conditions before they become severe or change lifestyles to eliminate future problems.

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