Key Healthcare Insurance Terms

Agent: A person who represents an insurance company and solicits or sells the company's insurance products. An agent may represent a single company or multiple companies.

Claim: A request that you or your health care provider makes to the health plan to pay for a health care service provided to you. Most health plans require claims to be in writing. Health plans require claims to be on a specific standard form.

Co-insurance: The amount you are required to pay for medical care in a fee-for-service plan after you have met your deductible. The coinsurance rate is usually expressed as a percentage. For example, if the insurance company pays 80% of the claim, then you pay 20%.

Co-payment: A dollar amount that you pay for a covered health care service. For example, your health plan may require that you pay $10 each time you go to the doctor.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A federal law in effect since 1986. COBRA permits you and your dependents to continue in your employer's group health plan after your job ends. If your employer has 20 or more employees, you may be eligible for COBRA continuation coverage when you retire, quit, are fired, or work reduced hours. Continuation coverage also extends to surviving, divorced, or separated spouses; dependent children; and children who lose their dependent status under the rules of their parent's plan. You may choose to continue in the group health plan for a limited time and pay the full premium, including the share your employer used to pay on your behalf. COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances.

Continuous Coverage: Under federal rules, health insurance coverage that is not interrupted by a break of 63 or more consecutive days. Employer waiting periods and HMO (Health Maintenance Organization) affiliation periods do not count as gaps in health insurance coverage for the purpose of determining whether coverage is continuous. See also Creditable Coverage and HIPAA Eligible.

Covered Expenses: Most insurance plans, whether they are fee for service, HMOs (Health Maintenance Organizations), or PPOs (Preferred Provider Organizations), do not pay for all services. Some may not pay for prescription drugs. Others may not pay for mental health care. Covered services are those medical procedures the insurer agrees to pay for. They are listed in the policy.

Deductible: The amount of money you are required to pay for health care services before your health plan starts paying the bill. Not all plans require deductibles.

Effective Date: The date on which coverage under an insurance policy begins.

Emergency Care: Health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize sudden and severe medical conditions.

Elimination Rider: An amendment in individual health insurance policy contracts that permanently excludes your coverage for a health condition, body part, or body system.

Enrollment Period: The period during which all employees and their dependents can sign up for coverage under an employer group health plan. Besides permitting workers to elect health benefits when first hired, many employers and group health insurers hold an annual enrollment period, during which all employees can enroll in or change health coverage. See also Group Health Plan and Special Enrollment Period.

Exclusions: Charges, services, or supplies that are not covered under an insurance policy.

Fee for Service: A health plan that allows you to go to any physician or provider you choose, but requires that you pay for the services and then file claims for reimbursement. (Also known as an indemnity plan.)

Guaranteed Renewable: Policies that may not be non-renewed or canceled, except in certain cases. An insurer may cancel a guaranteed renewable policy for failure to pay premiums, fraud, or intentional material misrepresentation. It also may cancel your policy if the company formally leaves the individual or group health market.

Health Insurance: Financial protection against all or part of the medical care costs to treat illness or injury. Health insurance may also include benefits for preventive health care to help you stay healthy.

Health Insurance Portability and Accountability Act (HIPAA) of 1996: A federal law that includes important health insurance provisions, including non-discrimination, guaranteed renewability, guaranteed issue, and limits to benefit exclusions because of pre-existing medical conditions.

Health Maintenance Organization (HMO): A prepaid health plan. You pay a monthly premium and the HMO covers your doctors' visits, hospital stays, emergency care, surgery, checkups, lab tests, x-rays, and therapy. You must use the doctors and hospitals designated by the HMO.

Health Reimbursement Arrangement (HRA): An alternative to traditional insurance coverage. HRAs are usually paired with a high-deductible health insurance policy; the contribution is tax-deductible. HRA funds may be used to pay out-of-pocket costs (e.g., deductibles, coinsurance, and co-pays). The employer must fund the HRA and consequently may decide if benefits are portable or will roll over from year to year.

Health Savings Account (HSA): An alternative to traditional insurance coverage. HSAs must be paired with a high-deductible health insurance policy; the contribution is tax-deductible. HSA funds may be used to pay out-of-pocket costs (e.g., deductibles, coinsurance, and co-pays). The employer, the employee, or both may fund the plan. HSAs are owned by the employee and are fully portable, and remaining balances roll over from year to year.

High-Deductible Health Plan (HDHP): Sometimes referred to as a “catastrophic” health insurance plan or a “consumer-driven health plan”, an HDHP is a plan that features higher annual deductibles than other traditional insurance plans in exchange for lower monthly premiums. Once the annual deductible is met, HDHPs generally cover health care expenses after that. Some HDHPs are eligible for health savings accounts (HSAs) or health reimbursement accounts (HRAs), which can be used to pay the expenses the HDHP does not cover.

High-Risk Pools: In some states, these pools provide a health insurance option for individuals whose poor health creates a barrier to obtaining employer-based coverage. Premiums in high-risk pools are relatively high, and there is often a waiting period before benefits are available. However, many states have non-discrimination laws that eliminate the need for these pools.

Indemnity Plan: A health plan that allows you to go to any physician or provider you choose but requires that you pay for the services and then file claims for reimbursement. (Also known as a fee-for-service plan.)

Individual Insurance: A health insurance policy purchased by an individual rather than a group plan purchased by an employer.

Large Group Health Plan: A plan with more than 50 employees.

Lifetime Maximum: The total dollar amount a health care plan will pay over a policyholder’s lifetime.

Long-Term Care Benefits: Coverage that provides help for people when they are unable to care for themselves because of prolonged illness or disability. Benefits are triggered by specific findings of "cognitive impairment" or inability to perform certain actions known as "activities of daily living." Benefits can range from help with daily activities while recuperating at home to skilled nursing care provided in a nursing home.

Major Medical Policies: Health care policies that usually cover both hospital stays and physicians´ services in and out of the hospital.

Managed Health Care: A system that organizes physicians, hospitals, and other health care providers into networks with the goal of lowering costs while still providing appropriate medical services. Many managed care systems focus on Preventive care and case management to avoid treating more costly illnesses.

Mandated Offerings: Health care benefits that must be offered to the employer or organization sponsoring a group policy. The sponsor is not required to include the benefits in its group plan.

Maximum Out-of-Pocket Expense: The maximum amount someone covered under a health care plan must pay during a certain period of time for expenses covered by the plan. Until the maximum is reached, the person covered is required to pay a co-payment or a percentage of each claim.

Medicaid: A health care program for people who meet certain income and other guidelines. Medicaid is paid for by federal and state funds.

Medical Underwriting: A pricing practice used by insurance companies to adjust premiums (usually upward) based on a group's health status or medical claims experience.

Medical Savings Account (MSA): A tax-deferred account established to pay for medical expenses not covered by an insurance policy.

Medicare (Title XVIII): A federal health insurance program for people over age 65 and for certain people with disabilities.

Medicare Supplemental Insurance: A policy that covers certain medical expenses not fully covered by Medicare.

Network: All physicians, specialists, hospitals, and other providers who have agreed to provide medical care to HMO (Health Maintenance Organization) members under terms of the contract with the HMO. Insurance contracts with PPO (Preferred Provider Organization) benefits also use networks.

Noncancellable Policy: A policy that guarantees you can receive insurance, as long as you pay the premium. Also called a "guaranteed renewable policy".

Non-Network Providers: Health care providers and treatment facilities not under contract with an HMO (Health Maintenance Organization) or those that do not have an insurance PPO (Preferred Provider Organization) contract. (Also called non-participating provider)

Out-of-Pocket Costs: Health care expenses paid by you because they are not paid by an insurer or HMO (Health Maintenance Organization).

Out-of-Network Services: Health care services from providers not in an HMO or a PPO´s network. Except in certain situations, HMOs will only pay for care received within its network. If you're in a PPO plan, you will have to pay more to receive services outside the PPO´s network.

Outpatient Services: Services usually provided in clinics, physician or provider offices, hospital-based outpatient departments, home health services, ambulatory surgical centers, hospices, and kidney dialysis centers.

Point-of-Service (POS) Plans: A plan that allows an HMO (Health Maintenance Organization) to contract with an insurance company to give enrollees the option of receiving services outside the HMO´s network. In Texas, HMOs must contract with an insurance company to offer POS plans.

Pre-Existing Condition Exclusion Period: The time during which a health plan will not pay for covered care relating to a pre-existing condition. See also Pre-Existing Condition.

Pre-Existing Condition: A health problem that existed before the date your insurance became effective.

Preferred Provider Organization (PPO): A network of medical providers that contracts with an insurer to provide services at pre-negotiated fees. PPOs are associated with insurance companies.

Premium: The amount that you and/or your employer pay for health insurance, usually paid in installments.

Preventive Care: Health care that focuses on healthy behavior and providing services that help prevent health problems. This includes health education, immunizations, early disease detection, health evaluations, and follow-up care.

Prior Authorization: Approval of a health care service or medication before it is provided in order for the health plan to cover the expense.

Provider Network: All the doctors, specialists, hospitals, and other providers who agree to provide medical care to HMO (Home Maintenance Organization) or PPO (Preferred Provider Organization) members under terms of a contract with the HMO or insurance company

Referral: A direction from your doctor to receive care from a different provider or facility.

Special Enrollment Period: A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 days. Enrollment in a health plan during a special enrollment period is not considered late enrollment.

State Continuation Coverage: A law in many states that is similar to COBRA in that it covers persons who work for employers with 2–19 employees. Also called “Expanded COBRA” and “mini-COBRA”

Underwriting: The process insurance companies use to examine, accept, reject, and classify the risks associated with a person or group who is applying for coverage.

Waiting Period: The time you may be required to work for an employer before you are eligible for health benefits. Not all employers require waiting periods. Waiting periods do not count as gaps in health insurance for purposes of determining whether coverage is continuous. If your employer requires a waiting period, your pre-existing condition exclusion period begins on the first day of the waiting period.