

Individual Health Insurance Glossary

Agent. An individual licensed by the state who sells insurance products and services to the public.

Annual Plan Deductible. A specific dollar amount that the insured must pay out-of-pocket each year before the insurance company will make any benefit payments for claims.

Applicant. The person applying for an insurance policy.

Benefit. Amount an insurance company pays for an insured person, assignee, or beneficiary when the insured suffers a loss covered by the insurance policy.

Benefit Options. Insurance benefits not included in the policy which are available to the individual as an option at an additional premium.

Claim. A request by the insured person or provider that benefits be paid for a covered health care service or supply.

Coinsurance. The payment percentage an insured is required to pay for a medical claim, apart from any copayments or deductibles. For example, if an 80%/20% arrangement is chosen, the insured pays 20% of the eligible covered amount and the insurance company pays 80%.

Condition. Disease, illness, ailment, injury, bodily malfunction, or pregnancy of an individual.

Copayment. A specific charge an insured person pays to a provider for a specific health care service at the time it is received. For example, an insured may pay a "\$25 office visit copay" according to the insurance policy.

Cost Sharing. The sharing of costs between the insurance company and the insured person through deductibles, co-insurance and co-payments.

Coverage. The benefits that are eligible under an insurance policy, depending on plan choices made by the applicant.

Effective Date. The date health insurance begins.

Eligible Expenses. The portion of the medical care provider's services that is allowed for calculation of payment under the terms of the insurance policy.

Exclusion. Specific conditions, services or procedures listed in the insurance policy for which the insurance company will not provide coverage or benefit payment.

First-dollar Benefit. Eligible medical expense for which the insurance policy begins to pay claims without first requiring the insured to make an out-of-pocket contribution.

Lapse. Termination of an insurance policy due to non-payment of premiums.

Mandated Benefits. Benefits for medical conditions required by state or federal law to be included in health insurance policies.

Negotiated Fees. Service fees agreed upon by Preferred Provider Organizations (PPOs) and providers (doctors and hospitals). Rates are usually based on services as defined in the provider contract with the PPO, generally at a discount from what the provider would usually charge. Participating providers cannot charge more than the agreed upon amount.

Network Providers. Limited grouping or panels of providers in a PPO arrangement. Insureds may be required to use only network providers. There is additional liability to the insured for using non-network providers for medical services.

Out-of-pocket maximum (OOPM). The maximum amount that an insured is required to pay under an insurance policy per year.

Participating Provider. A provider who has agreed to contract with a PPO to provide services to covered persons at a discounted rate.

Renewal. Continuance of coverage under a policy beyond its original term by the insurance company's acceptance of the premium for a new term for the policy.

Pre-existing Condition. A health condition that existed before the effective date of the insurance policy.

Pre-existing Condition Clause. A provision in an insurance policy that outlines the definition of what is considered a pre-existing condition and that benefits are not paid for a pre-existing condition.

Premium. Periodic payment to keep an insurance policy in force.

Preventive Care. Specified wellness and health promotion services that may be part of the benefits package of an insurance policy.

Reasonable and Customary. The maximum amount an insurance contract will consider eligible for reimbursement, based upon prevailing fees in a geographic area.

Rider (Exclusion). An amendment to an insurance policy that limits or excludes medical services or supplies. For example, a rider to a policy may exclude coverage for treatment for an applicant's knee.

Underwriting. The process of determining whether or not the insurance company will accept an insurance application or what conditions will not be covered along with any changes to the premium due to underwriting.

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