DICTIONARY OF HEALTH INSURANCE TERMS

PRESS THE CONTROL / F KEY TO SEARCH

ADL

See Activities of Daily Living Standards.A&H, A&S. Accident and Health Insurance, Accident and Sickness Insurance. Once commonly used as generic designations for the entirefield now called Health Insurance. See Health Insurance.

ACCELERATED BENEFITS

Riders on life insurance policies which allow the lifeinsurance policy's death benefits to be used to offset expenses incurred in a convalescent or nursing homefacility.

ACCESS

The availability of medical care to a patient. This can bedetermined by location, transportation, type of medicalservices in the area, etc.

ACCIDENT AND SICKNESS INSURANCE (A&S)

An older name for Health Insurance. See Health Insurance.

ACCIDENT INSURANCE

A form of insurance against loss by accidental bodily injuryto the insured.

ACCIDENTAL DEATH AND DISMEMBERMENT

A policy or a provision in a Disability Income policy whichpays either a specified amount or a multiple of the weeklydisability benefit if the insured dies, loses his or hersight, or loses two limbs as the result of an accident. Alesser amount is payable for the loss of one eye, arm, leg,hand, or foot.

ACCIDENTAL DEATH BENEFIT

An extra benefit which generally equals the face of thecontract or principal sum, payable in addition to otherbenefits in the event of death as the result of an accident.See also Double Indemnity and Multiple Indemnity.

ACCIDENTAL DEATH INSURANCE

A form that provides payment if the death of the insuredresults from an accident. It is often combined withDismemberment Insurance in a form called Accidental Deathand Dismemberment. See also Accidental Death andDismemberment.

ACCRETE

A Medicare term which means the process of adding newmembers to a health plan.

ACTIVELY-AT-WORK

Most group health insurance policies state that if anemployee is not actively at work on the day the policy goesinto effect, the coverage will not begin until the employeedoes return to work.

ACTIVITIES OF DAILY LIVING (ADL)

Everyday living functions and activities performed byindividuals without assistance. These functions wouldinclude mobility, dressing, personal hygiene and eating.

ACTIVITIES OF DAILY LIVING (ADL) STANDARDS

Used to assess the ability of an individual to liveindependently, measured by the ability to perform unaidedsuch activities as eating, bathing, toiletry, dressing, andwalking. ADL standards are sometimes discussed as a way tomeasure or define eligibility for long term care.

ACTUAL CHARGE

The actual amount charged by a physician for medicalservices rendered.

ACUTE CARE

Skilled, medically necessary care provided by medical andnursing personnel in order to restore a person to goodhealth.

ADDITIONAL DRUG BENEFIT LIST

Prescription drugs listed as commonly prescribed byphysicians for patients' long-term use. Subject to review and change by the health plan involved. Also called drugmaintenance list.

ADDITIONAL MONTHLY BENEFIT

Riders added to disability income policies to provideadditional benefits during the first year of a claim whilethe insured is waiting for Social Security benefits tobegin.

ADJUSTED AVERAGE PER CAPITA COST (AAPCC)

The estimated average cost of Medicare benefits establishedon a per county basis _ factors include age, sex, Medicaid,institutional status, disability, and end stage renaldisease status. Used to determine payments to costcontractors for Medicare benefits.

ADJUSTED COMMUNITY RATING (ACR)

Community rating adjusted by factors specific to aparticular group. Also known as factored rating.

ADMISSIONS/1,000

The number of hospital admissions for each 1,000 members ofthe health plan.

ADMITS

The number of admissions to a hospital (including outpatientand inpatient facilities).

ADULT DAY CARE

A group program for functionally impaired adults, designedto meet health, social and functional needs in a settingaway from the adult's home.

AFTERCARE

Individualized patient services required afterhospitalization or rehabilitation.

AGE CHANGE

The date on which a person's age, for insurance purposes, changes. In most Life Insurance contracts this is the datemidway between the insured's natural birth dates. Health insurers frequently use the age of the previous birth datefor rate determinations. On the date of age change, aperson's age may change to that of the last birth date, the nearer birth date, or the next birth date, depending uponthe way in which the rating structure has been establishedby that particular insurer.

AGE/SEX FACTOR

Compares the age and sex risk of medical costs of one grouprelative to another. An age/sex factor above 1.00 indicateshigher than average risk of medical costs due to thatfactor.

Conversely, a factor below 1.00 indicates a lowerthan average risk. This measurement is used in underwriting.

AGE/SEX RATES (ASR)

Separate rates are established for each grouping of age andsex categories. Preferred over single and family ratingbecause the rates and premiums automatically reflect changesin the age and sex content of the group. Also sometimescalled table rates.

AGGREGATE INDEMNITY

A maximum dollar amount that may be collected by theclaimant for any disability, for any period of disability,or under the policy as a whole.

ALLIED HEALTH PERSONNEL

Health personnel who perform duties which would otherwisehave to be performed by physicians, optometrists, dentists,podiatrists, nurses, and chiropractors. Also calledparamedical personnel.

ALLOCATED BENEFITS

Payments authorized for specific purposes with a maximumspecified for each. In hospital policies, for instance,there may be scheduled benefits for X-rays, drugs,dressings, and other specified expenses.

ALLOWABLE CHARGE

The lesser of the actual charge, the customary charge andthe prevailing charge. It is the amount on which Medicarewill base its Part B payment.

ALLOWABLE COSTS

Charges which qualify as covered expenses.Alternative Delivery SystemsSystems which cover health care costs, other than on theusual fee-for-service basis. Could include HMOs, IPAs, PPOs,etc.

ALZHEIMER'S DISEASE

A progressive, irreversible disease characterized bydegeneration of the brain cells and severe loss of memorycausing the individual to become dysfunctional and dependentupon others for basic living needs.

AMBULATORY CARE

Similar to outpatient treatment in that it is care whichdoes not require hospitalization.

AMBULATORY SETTING

Institutions such as surgery centers, clinics, or otheroutpatient facilities which provide health care on anoutpatient basis.

ANCILLARY

Additional services (other than room and board charges) suchas X-rays, anesthesia, lab work, etc. Fees charged forancillary care such as X-rays, anesthesia, and lab work.This term may also be used to describe the charge made by apharmacy for prescriptions which exceed the health insuranceplan's maximum allowable cost (MAC).

ANCILLARY BENEFITS

Benefits for miscellaneous hospital charges.

APPROVED CHARGE

Amounts paid under Medicare as the maximum fee for a coveredservice.

APPROVED HEALTH CARE FACILITY OR PROGRAM

A facility or program which has been approved by a healthcare plan as described in the contract.

ASSIGNMENT

An authorization to pay Medicare benefits directly to theprovider. Medicare payments may be assigned to participatingproviders only.

ASSIGNMENT OF BENEFITS

A method where the person receiving the medical benefitsassigns the payment of those benefits to a physician orhospital.

AVERAGE COST PER CLAIM

The total cost of administrative and/or medical servicesdivided by the number of units of exposure such as costsdivided by number of admissions, or cost divided by numberof outpatient claims, etc.

AVERAGE LENGTH OF STAY (ALOS)

The total number of patient days divided by the number ofadmissions and discharges during a specified period of time.This gives the average number of days in the hospital foreach person admitted.

AVERAGE WHOLESALE PRICE (AWP)

Under the Medicare catastrophic coverage act, payment forprescription drugs is limited to the lowest of thepharmacy's actual charge, the sum of the AWP for the drug plus an administrative allowance, or effective 1992, the90th percentile of pharmacy charges.

BASE CAPITATION

The total amount which covers the cost of health care perperson, minus any mental health or substance abuse services,pharmacy, and administrative charges.

BASIC HOSPITAL EXPENSE INSURANCE

Hospital coverage providing benefits for room and board andmiscellaneous hospital expenses for a specified number ofdays during hospital confinement.

BED DAYS/1,000

The number of inpatient hospital days per 1,000 members ofthe health plan.

BENEFIT LEVELS

The maximum amount a person is entitled to receive for aparticular service or services as spelled out in thecontract with a health plan or insurer.

BENEFIT PACKAGE

A description of what services the insurer or health planoffers to those covered under the terms of a healthinsurance contract.

BENEFIT PERIOD

Defines the period during which a Medicare beneficiary iseligible for Part A benefits. A benefit period is 90 dayswhich begins the day the patient is admitted to a hospitaland ends when the individual has not been hospitalized for aperiod of 60 consecutive days.

BILLED CLAIMS

The amounts submitted by a health care provider for servicesprovided to a covered individual.

BINDING RECEIPT

See Conditional Binding Receipt.

BIRTHDAY RULE

One method of determining which parent's medical coveragewill be primary for dependent children: the parent whosebirthday falls earliest in the year will be considered ashaving the primary plan.

BLANKET INSURANCE

A contract of Health Insurance that covers all of a class ofpersons not individually identified in the contract.

BLANKET MEDICAL EXPENSE

A policy or provision in a Health Insurance contract thatpays all medical costs, including hospitalization, drugs,and treatments, without limitation on any item exceptpossibly for a maximum aggregate benefit under the policy.It is often written with an initial deductible amount.

BLUE CROSS

Blue Cross plans are nonprofit hospital expense prepaymentplans designed primarily to provide benefits forhospitalization coverage, with certain restrictions on thetype of accommodations to be used.

BLUE PLAN

A generic designation for those companies, usually writing aservice rather than a reimbursement contract, who areauthorized to use the designation Blue Cross or Blue Shieldand the insignia of either.

BLUE SHIELD

Blue Shield plans are prepayment plans offered by voluntarynonprofit organizations covering medical and surgicalexpenses.

BOARD CERTIFIED

A physician or other professional who has passed anexamination which certifies him or her as a specialist in aparticular medical area.

BOARD ELIGIBLE

A professional person or physician who is eligible to take aspecialty examination.

BUSINESS OVERHEAD EXPENSE

A disability income policy which indemnifies the businessfor certain overhead expenses incurred when the businessowner is totally disabled.

CCRCS

See Continuing Care Retirement Communities (CCRCs).

COB

Coordination of Benefits. See Nonduplication of Benefits.

COBRA

See Consolidated Omnibus Budget Reconciliation Act of 1986.

CALENDAR YEAR

January 1 through December 31 of the same year. Manydeductible amount provisions are on a calendar year basisunder major medical plans. Also, benefits under basichospital surgical and medical plans are usually stated as somuch for each calendar year.

CAPITATION (CAP)

A rate paid, usually monthly, to a health care provider. Inreturn, the provider agrees to deliver the health servicesagreed upon to any covered person.

CARRIER

Usually a commercial insurer contracted by the Department ofHealth and Human Services to process Part B claims payments.

CARRIER REPLACEMENT

This refers to a situation where one carrier replaces one ormore carriers.

CARRY OVER PROVISION

In major medical policies, allowing an insured who hassubmitted no claims during the year to apply any medicalexpenses incurred in the last three months of the yeartoward the new calendar year's deductible.

CASE MANAGEMENT

The assessment of a person's long term care needs and theappropriate recommendations for care, monitoring andfollow-up as to the extent and quality of services to beprovided.

CASE MANAGER

A person, usually an experienced professional, whocoordinates the services necessary under the case managementapproach.

CASE MIX

The number of cases requiring different needs and uses ofhospital resources.

CATASTROPHE POLICY

This is an older name for Major Medical. See Major Medical.

CERTIFICATE OF AUTHORITY (COA)

Issued by the state, it licenses the operation of an HMO(Health Maintenance Organization).

CERTIFICATE OF NEED (CON)

Issued by a governmental body. It certifies that theproposed facility will meet the needs of those for whom itis intended. Such need might involve constructing a newhealth facility, offering a new or different health service,or acquiring new medical equipment.

CESTUI QUE VIE

The person whose life measures the duration of a trust,gift, estate, or insurance contract. Thus, in Life andHealth Insurance it is the person on whose life or healththe policy is written, commonly called the insured,policyholder, or policy owner.

CHEMICAL DEPENDENCY SERVICES

The services required in the treatment and diagnosis ofchemical dependency, alcoholism, and drug dependency.

CHEMICAL EQUIVALENTS

Drugs which contain identical amounts of the sameingredients.

CHRISTIAN SCIENCE ORGANIZATION

A religious organization which is certified by the FirstChurch of Christian Scientists. The organization may also beMedicare certified as a hospital or skilled nursingfacility.

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMEDSERVICES (CHAMPUS)

Part of the Uniformed Services Health Benefits Program whichsupplements the medical care available for families ofactive, deceased, and retired military personnel.

CLOSED ACCESS

A situation where covered insureds must select one primarycare physician. That physician is the only one allowed torefer the patient to other health care providers within theplan. Also called Closed Panel or Gatekeeper model.

CLOSED PANEL

See Closed Access.

COGNITIVE IMPAIRMENT

A deficiency in the ability to think, perceive, treason orremember resulting in loss of the ability to take care ofone's daily living needs.

COINSURANCE CLAUSE

A provision stating that the insured and the insurer willshare all losses covered by the policy in a proportionagreed upon in advance, i.e., 80-20 would mean that theinsurer would pay 80% and the insured would pay 20% of alllosses. See also Percentage Participation.

COMMERCIAL POLICY

In Health Insurance, this term originally applied to policyforms intended for sale to individuals in commerce, ascontrasted with industrial workers. Currently the term isloosely used to mean all policies that do not guaranteerenewability.

COMMUNITY RATING

Under this rating system, the charge for insurance to allinsureds depends on the medical and hospital costs in thecommunity or area to be covered. Individual characteristicsof the insureds are not considered at all.

COMPETITIVE MEDICAL PLAN (CMP)

This refers to permission given by the federal governmentthat allows an organization to write a Medicare riskcontract.

COMPOSITE RATE

One rate for all members of the group regardless of theirstatus as single or members of a family.

COMPREHENSIVE MAJOR MEDICAL

A plan of insurance which has a low deductible, high maximumbenefits, and a coinsurance feature. It is a combination ofbasic coverage and major medical coverage which hasvirtually replaced separate hospital, surgical and medicalpolicies with each having its own deductible requirements.Also see Major Medical Insurance.

CONCURRENT REVIEW

A case management technique which allows insurers to monitoran insured's hospital stay and to know in advance if thereare any changes in the expected period of confinement andthe planned release date.

CONDITIONAL BINDING RECEIPT

This is the more exact terminology for what is often calleda binding receipt. It provides that if a premium accompaniesan application, the coverage will be in force from the dateof application or medical examination, if any, whichever islater, provided the insurer would have issued the coverageon the basis of the facts revealed on the application,medical examination and other usual sources of underwritinginformation. A Life and Health Insurance policy without aconditional binding receipt is not effective until it isdelivered to the insured and the premium is paid.

CONDITIONALLY RENEWABLE

A contract that provides that the insured may renew it to astated date or an advanced age, subject to the right of theinsurer to decline renewal only under conditions stated inthe contract.

CONFINING

A form of disability or sickness that confines the insuredindoors, usually at home or in a hospital. Many policiesstate that coverage is afforded only if the insured isconfined.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) OF 1986

Legislation providing for a continuation of group healthcare benefits under the group plan for a period of time whenbenefits would otherwise terminate. Continuation rightsapply to enrolled persons and their dependents. Coverage maybe continued for up to 18 months if the insured personterminates employment or is no longer eligible. Coverage maybe continued for up to 36 months in nearly all other cases,such as loss of dependent eligibility because of death ofthe enrolled person, divorce, or attainment of the limitingage.

CONTINUATION

Allows terminated employees to continue their group healthinsurance coverage under certain conditions.

CONTINUING CARE RETIREMENT COMMUNITIES (CCRCS)

Residential communities set up to provide residents witheasy access to health care.

CONTRACT YEAR

This period runs from the effective date to the expirationdate of the contract.

COORDINATION OF BENEFITS (COB)

See Nonduplication of Benefits.

COORDINATION OF BENEFITS (COB)

A group policy provision which helps determine the primarycarrier in situations where an insured is covered by morethan one policy. This provision prevents an insured fromreceiving claims overpayments.

COPAY

This is an arrangement where the covered person pays aspecified amount for various services and the health careprovider pays the remainder. The covered person usually mustpay his or her share when the service is rendered. Similarto coinsurance, except that coinsurance is usually apercentage of certain charges where the co-payment is adollar amount.

COPAY PROVISION

Often used with major medical policies. The copay provisionstates what percentage of a claim the company will pay andwhat percentage the insured will pay. For example, an 80percent copay provision would provide that the insurer pay80 percent of claims and the insured pay 20 percent.

COPAYMENT

See Copay.

CORRIDOR DEDUCTIBLE

A Major Medical deductible that provides for a deductible,or "corridor," after the full payment of basic hospital andmedical expenses up to a stated amount. In the event offurther expenses, payment is on the basis of participationor coinsurance, such as 80%-20% or 85%-15%, and thedeductible is that portion paid by the insured.

COSMETIC PROCEDURES

Procedures which improve the appearance, but are notmedically necessary.

COST CONTRACT

An agreement between a provider and the Health CareFinancing Administration to provide health services tocovered persons based on reasonable costs for service.

COST OF LIVING BENEFIT

An optional disability benefit where the monthly benefitwill be increased annually once the insured is on claim for12 months.

COST SHARING

A situation where covered persons pay a portion of thehealth costs such as deductibles, coinsurance, or copaymentamounts.

COVERED EXPENSES

Health care expenses incurred by an insured or coveredperson that qualify for reimbursement under the terms of apolicy contract.

COVERED PERSON

A person who pays premiums into the contract for thebenefits provided and who also meets eligibilityrequirements.

CREDENTIALING

This involves approving a provider based on certain criteriato provide or participate in a health plan.

CREDIT HEALTH INSURANCE

A group disability income insurance contract whereby acreditor is protected in the event of the total disabilityof a debtor. The policy will pay benefits equal to themonthly installment of the debtor.

CREDIT INSURANCE

Insurance on a debtor in favor of a creditor to pay off thebalance due on a loan in the event of the death ordisability of the debtor. Liability Insurance for abnormalloss from bad debts.

CUSTODIAL CARE

Care that is primarily for meeting personal needs such ashelp in bathing, dressing, eating or taking medicine. It canbe provided by someone without professional medical skillsor training but must be according to doctor's orders.

DBL

See Disability Benefits Law.

DATE OF SERVICE

The date that the health service was provided.

DEATH SPIRAL

The potentially destructive cycle that may occur in anindemnity plan as a result of increased HMO penetration. Theprocess can occur if indemnity plan rates continuouslyescalate because healthier and younger employees chooseHMOs, leaving less healthy individuals in experience-ratedindemnity plans. Employer contribution strategies and HMOpricing techniques may aggravate the problem.

DEDUCTIBLE CARRYOVER CREDIT

During the last three months of a calendar year, chargesincurred for health services can be used to satisfy thedeductible for the following calendar year. These creditsmay be applied whether or not the prior calendar year'sdeductible had been met.

DEFERRED COMPENSATION ADMINISTRATOR

This refers to a company that provides services under adeferred compensation plan. Services may includeadministration of self-insured plans, compensation planning,salary surveys, retirement planning, etc.

DELETE

This refers to the process of taking an individual off Medicare coverage.

DENTAL INSURANCE

A group Health Insurance contract that provides payment forcertain enumerated dental services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

A federal department whose responsibility is primarilydealing with social service functions such as administrationand supervision of the Medicare program.

DEPENDENT COVERAGE

Insurance coverage on the head of a family which is extendedto his or her dependents, including only the lawful spouseand unmarried children who are not yet employed on afull-time basis. "Children" may be step, foster, andadopted, as well as natural. Certain age restrictions onchildren usually apply.

DESIGNATED MENTAL HEALTH PROVIDER

The organization hired by a health plan to provide mentalhealth and substance abuse services.

DETOXIFICATION

The process an individual goes through when withdrawing from alcohol. Usually is done under guidance of medical personnel.

DIAGNOSIS

The process of identifying a disease.Diagnosis Related Groups (DRGs)A method of classifying inpatient hospital services. It isused as a method of determining financing to reimbursevarious providers for services performed.

DISABILITY BENEFITS LAW

A state law requiring an employer to provide disabilitybenefits to covered employees for nonoccupational injuries,in contrast to Workers Compensation, which pays foroccupational injuries. These laws are currently in effect inNew York, New Jersey, Rhode Island, California, and Hawaii.

DISABILITY BUY-SELL

A disability income policy used to fund a disabilitybuy-sell agreement whereby the business interest of adisabled stockholder following the elimination period. Thepolicy's benefits may be paid in a lump sum or ininstallments.

DISABILITY INCOME INSURANCE

A form of health insurance that provides periodic paymentsto replace income, actually or presumptively lost, when theinsured is unable to work as a result of sickness or injury.

DISABILITY INSURANCE TRAINING COUNCIL, INC

The educational arm of the International Association ofHealth Underwriters, the Health Insurance agents'professional society. It seeks to encourage agenteducational projects by local Health associations, conductsuniversity seminars in advanced Health underwriting areas,and conducts annual seminars for home office executives insociological social insurance and demographic trends thatmay affect future application of policy forms and HealthInsurance.

DISABILITY, LONG-TERM

See Long-Term Disability.

DISABILITY, PERMANENT PARTIAL

See Permanent Partial Disability. (WC,H)

DISABILITY, PERMANENT TOTAL

See Permanent Total Disability. (WC,H)

DISABILITY, SHORT-TERM

See Short-Term Disability.

DISABILITY, TEMPORARY PARTIAL

See Temporary Partial Disability. (WC,H)

DISABILITY, TEMPORARY TOTAL

See Temporary Total Disability. (WC,H)

DISCHARGE PLANNING

Determining what the patient's medical needs will be afterdischarge from a hospital or other inpatient treatment.

DISMEMBERMENT

The loss of, or loss of use of, specified members of thebody resulting from accidental bodily injury.

DISMEMBERMENT BENEFIT

The benefits payable for various types of dismemberment. Seealso Accidental Death and Dismemberment and MultipleIndemnity.

DREAD (OR SPECIFIED) DISEASE POLICY

Coverage, usually with a high maximum limit, for all typesof medical expenses arising out of diseases named in thecontract. Common diseases covered are poliomyelitis,diphtheria, multiple sclerosis, spinal meningitis, andtetanus. Cancer is sometimes covered or may be added withsome companies by a rider.

DRUG FORMULARY

A schedule of prescription drugs approved for use which willbe covered by the plan and dispensed through participatingpharmacies.

DRUG PRICE REVIEW (DPR)

A procedure used to determine drug price maximums. Itinvolves determining wholesale drug prices based on theAmerican Druggist Blue Book.

DRUG UTILIZATION REVIEW (DUR)

A method for evaluating or reviewing the use of drugs inorder to determine the appropriateness of the drug therapy.

DUAL CHOICE

The federal requirement that employers having 25 or moreemployees who are within the service area of a federallyqualified HMO, who are paying at least minimum wage andoffer a health plan to their employees, must offer HMOcoverage as well as an indemnity plan.

DUPLICATE COVERAGE INQUIRY (DCI)

A request to determine whether or not other coverage exists.Used to apply the coordination of benefits provisions wheretwo or more insurance companies are involved.

DUPLICATION OF BENEFITS

A situation where identical or overlapping coverage existsbetween two or more insurance companies or serviceorganizations.

ERISA

See Employee Retirement Income Security Act. (H,LI)

ELECTIVE BENEFITS

Lump sum payments which the insured may generally choose inlieu of periodic payments for certain injuries, such asfractures and dislocations.

ELECTIVE INDEMNITIES

See Elective Benefits.

ELIGIBILITY DATE

The date that a person is eligible for benefits.

ELIGIBILITY PERIOD

(1) The period of time during which potential members of aGroup Life or Health program may enroll without providingevidence of insurability. (2) The period of time under aMajor Medical policy during which reimbursable expenses maybe accrued.

ELIGIBILITY REQUIREMENTS

Requirements imposed for eligibility for coverage, usuallyin a group insurance or pension plan.

ELIGIBLE DEPENDENT

A dependent of an insured person who is eligible forcoverage according to the requirements set forth in thecontract.

ELIGIBLE EMPLOYEE

An employee who is eligible based on the requirements asindicated in the group contract.

ELIGIBLE EXPENSES

Expenses as defined in the health plan as being eligible forcoverage. This could involve specified health services feesor "customary and reasonable charges."

ELIGIBLE PERSON

Similar to eligible employee except it could be a contractcovering people who are not employees of a specifiedemployer. An example might be members of an association,union, etc.

ELIMINATION PERIOD

A loosely used term, sometimes designating the probationaryperiod, but most often designating the waiting period in aHealth Insurance policy. See also Probationary Period andWaiting Period.

EMERGENCY

An injury or disease which happens suddenly and requirestreatment within 24 hours.

EMERGENCY ACCIDENT BENEFIT

A group medical benefit which reimburses the insured forexpenses incurred for emergency treatment of accidents.

EMERGI-CENTER

See Freestanding Emergency Medical Services Center.

EMPLOYEE BENEFIT PROGRAM

Benefits offered an employee at his place of work by hisemployer, covering such contingencies as medical expenses,disability, retirement, and death, usually paid for whollyor in part by the employer. These benefits are usuallyinsured.

EMPLOYEE CERTIFICATE OF INSURANCE

The employee's evidence of participation in a groupinsurance plan, consisting of a brief summary of planbenefits. The employee is provided with a certificate ofinsurance rather than the actual insurance policy.

EMPLOYEE CONTRIBUTION

The employee's share of the premium costs.

EMPLOYER CONTRIBUTION

The portion of the cost of a health insurance plan which isborne by the employer.

ENCOUNTER

Each time a person meets with a health care provider toreceive services, is a separate "encounter."

ENCOUNTERS PER MEMBER PER YEAR

The total number of encounters per year divided by the totalnumber of members per year.

ENROLLEE

An eligible individual who is enrolled in a health plan _does not include an eligible dependent.

ENROLLING UNIT

The organization (such as an employer) that contracts forparticipation in a health insurance plan.

ENROLLMENT

Used to describe the total number of enrollees in a healthplan. It may also be used to refer to the process of enrolling people in a health plan.

ENROLLMENT PERIOD

The amount of time an employee has to sign up for acontributory health plan.

ENTIRE CONTRACT CLAUSE

A provision in an insurance contract stating that the entireagreement between the insured and the insurer is contained in the contract, including the application if it isattached, declarations, insuring agreements, exclusions,conditions and endorsements.

EVIDENCE OF COVERAGE

See Certificate of Coverage.

EVIDENCE OF INSURABILITY

The statement of information needed for the underwriting of an insurance policy.

EXAMINATION

The medical examination of an applicant for Life or Health insurance.

EXAMINED BUSINESS

Coverage written on an applicant who has been examined and who has signed the application but has paid no premium.

EXAMINER

A physician appointed by the medical director of a Life orHealth insurer to examine applicants.

EXCEPTED PERIOD

See Probationary Period.

EXCLUDED PERIOD

See Probationary Period.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

A type of preferred provider organization where individua lmembers use particular preferred providers rather thanhaving a choice of a variety of preferred providers. EPOsare characterized by a primary physician who monitors careand makes referrals to a network of providers.

EXPECTED CLAIMS

The estimated claims for a person or group for a contractyear based usually on actuarial statistics.

EXPECTED MORBIDITY

The expected incidence of sickness or injury within a given group during a given period of time as shown on a morbiditytable.

EXPENSE

A policy's share of the company's operating costs, fees formedical examinations and inspection reports, underwriting, printing costs, commissions, advertising, agency expenses,premium taxes, salaries, rent, etc. Such costs are importantin determining dividends and premium rates.

EXPERIMENTAL OR UNPROVEN PROCEDURES

Any health care services, supplies, procedures, therapies,or devices that the health plan determines regarding coverage for a particular case to be either (1) not provenby scientific evidence to be effective, or (2) not acceptedby health care professionals as being effective.

EXPLANATION OF BENEFITS (EOB)

The statement sent to a participant in a health plan listingservices, amounts paid by the plan, and total amount billed to the patient.

EXPLANATION OF MEDICARE BENEFITS

A notice which is sent to the Medicare patient whichprovides information designed to explain how the claim is to be paid.

EXTENDED CARE FACILITY

A facility such as a nursing home which is licensed toprovide 24-hour nursing care service in accordance with state and local laws. Three levels of care may beprovided--skilled, intermediate, custodial, or anycombination.

EXTENDED COVERAGE

A provision in certain Health policies, usually Group, toallow the insured to receive benefits for specified losses sustained after the termination of coverage, such amaternity expense benefits incurred for a pregnancy inprogress at the time of the termination.

EXTENSION OF BENEFITS

A condition in the insurance policy which allows coverage tocontinue beyond the expiration date of the policy in thecase of employees who are not actively at work or dependentswho are hospitalized on that date. The extended coverageapplies only where the employee or dependent is disabled asof that date and continues only until the employee returnsto work or the dependent leaves the hospital.

FASB

The Financial Accounting Standards Board.

FAMILY DEPENDENT

A person entitled to coverage because he or she is: 1. Theenrollee's spouse, or 2. A single dependent child of eitherthe enrollee or the enrollee's spouse (includingstepchildren or legally adopted children), and 3. A residentof the enrollee's home.

FAMILY EXPENSE POLICYSADASD

A policy which insures the medical expenses of all membersof a family.

FEDERAL QUALIFICATION

Approval of any HMO made by the HCFA after conducting theirevaluation of methods of doing business, documents,contracts, facilities, and systems.

FEE-FOR-SERVICE EQUIVALENCY

The difference between the amount a provider receives from areimbursement system such as capitation (a flat charge permonth, for instance) compared to fee-for-servicereimbursement.

FEE-FOR-SERVICE REIMBURSEMENT

A health care system where physicians and other providersreceive payment based on their billed charge for eachservice provided.

FEE MAXIMUM

The maximum amount available to a provider for specifichealth care services under a contract.

FEE SCHEDULE

A list of maximum fees for providers who are on afee-for-service basis.

Field Underwriting

The initial screening of prospective buyers of healthinsurance, performed by sales personnel "in the field." Mayalso include quoting of premium rates.

FINANCIAL ACCOUNTING STANDARDS BOARD (FASB)

A non-governmental group that sets standards for generallyaccepted accounting principles.

FISCAL INTERMEDIARY

A commercial insurer contracted by the Department of Healthand Human Services for the purpose of processing andadministering Part A Medicare claims.

FLAT MATERNITY BENEFIT

A stipulated benefit in a Hospital Reimbursement policy thatis paid for maternity confinement, regardless of the actualcost of the confinement.

FLEXIBLE BENEFIT PLAN

A type of program where employees can tailor their benefitsto meet their own specific needs.

FORMULARY

See Drug Formulary.

FRANCHISE INSURANCE

A plan for covering groups of persons with individualpolicies having uniform provisions, although they may differin benefits. Individual contracts are issued to each personwith individual underwriting. It is usually applied togroups too small to qualify for true group coverage, and thesolicitation of cases usually takes place among anemployer's work force with his consent. In Life Insurance,it is sometimes called Wholesale Insurance. Contrast withTrue Group Insurance.

FRATERNAL INSURANCE

Insurance offered a special group of people, namely, membersof a lodge or a fraternal order. Such insurance may bewritten on an assessment basis or on a legal reserve basis.

FREE-STANDING EMERGENCY MEDICAL SERVICE CENTER

A facility whose primary purpose is the provision of carefor emergency medical conditions. Also called emergi-centeror urgi-center.

FREE-STANDING OUTPATIENT SURGICAL CENTER

A facility which only provides outpatient surgical services.Also called surgi-center.

FREQUENCY

The number of times a service is provided over a given timeperiod.

FRINGE BENEFITS

See Employee Benefit Program. (LA,H)***

FUNDING LEVEL

The dollar amount required to purchase a particular medicalcare program. Usually measured by the premium rate for aninsured program, or an amount assessed for expected claimloss and related fees under a self-funded program.

FUNDING METHODS

The agreed means by which an employer pays for healthcoverage. Future Increase Option. An option which allowsthe insured to increase disability income benefits atpredetermined times, specified in the policy, withoutevidence of insurability.

GAMC

See General Agents and Managers Conference.

GATEKEEPER MODEL

Under this model of HMO and PPO organizations, the primarycare physician (the gatekeeper) is the initial contact forthe patient for medical care and for referrals. This is alsocalled a closed access or closed panel.

GENERAL AGENT (GA)

An individual appointed by a Life or Health insurer toadminister its business in a given territory. He isresponsible for building his own agency and service forceand is compensated on a commission basis, although hepossibly has some additional expense allowances.General Agents and Managers ConferenceAn association of insurance general agents and managersaffiliated with the National Association of LifeUnderwriters.

GENERAL LTC RIDER

A LTC rider which is attached to a life insurance policy butstands alone or is independent of the life policy. Any LTCbenefits paid do not reduce any of the life insurancebenefits.

GENERIC DRUG

A drug which is exactly the same as a brand name drug andwhich is allowed to be produced after the brand name drug'spatent has expired. It is also called a "genericequivalent."

GENERIC EQUIVALENCE

See Generic Drug.

GRIEVANCE PROCEDURE

A procedure which allows a member of a health plan or aprovider of benefits to express complaints and seekremedies.

GROUP

Coverage of a number of individuals under one contract. Themost common "group" is employees of the same employer.

GROUP CERTIFICATE

The document provided to each member of a group plan. Itshows the benefits provided under the group contract issuedto the employer or other insured.

GROUP CONTRACT

A contract of insurance made with an employer or otherentity that covers a group of persons identified byreference to their relationship to the entity buying thecontract. The group contractual arrangement is generallyused to cover employees of a common employer, members of atrade association or trusteeship, members of a welfare oremployee benefit association, members of a labor union, ormembers of a professional or other association not formedonly for the purpose of obtaining insurance.

GROUP CREDIT INSURANCE

Insurance on the Life or Health of debtors of a creditor,payable for reduction or extinguishment of the debts in caseof the disability or death of the debtor.

GROUP DISABILITY INSURANCE

Coverage provided for a group of individuals for loss ofcompensation due to accident or sickness.

GROUP HEALTH INSURANCE

The same definition as Life Insurance but with theapplication to Health Insurance coverages. See Group LifeInsurance.

GROUP MODEL HMO

A health plan where a group of physicians is reimbursed forservices they provide at a negotiated rate. The HMO alsocontracts with hospitals for the care of the patients of thephysicians who belong to the group.

GUARANTEED STANDARD ISSUE (GSI)

An underwriting term used to describe the fact that a groupinsurance contract was issued without reference to anymedical underwriting. All group participants are coveredregardless of health history.

HCFA

Health Care Financing Administration.

HCFA 1500

A form used by providers of health services to bill theirfees to health carriers. It was developed by the governmentagency known as Health Care Financing Administration.

HI.2

See Health Insurance and Medicare, Part A.

HIAA

See Health Insurance Association of America.

HII

See Health Insurance Institute.

HIQA. HEALTH INSURANCE QUALITY AWARD

An award granted annually by the International Associationof Health Underwriters or the National Association of LifeUnderwriters for high persistency of Health Insurancepolicies written by agents. See also Persistency.

HMO

See Health Maintenance Organization.

HOME HEALTH AGENCY

A certified facility approved by a health plan to provideservices under contract.

HOME HEALTH CARE

Care received at home as part-time skilled nursing care,speech therapy, physical or occupational therapy, part-timeservices of home health aides or help from homemakers orchoreworkers.

HOME HEALTH SERVICES

Health care services provided by a licensed home healthagency in the patient's home which is a covered expenseunder Part A of Medicare.

HEALTH BENEFITS PACKAGE

The coverages offered by a health plan to an individual orgroup.

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Part of the Department of Health and Human Services,responsible for administration of the Medicare and Medicaidprograms. The HCFA establishes standards for medicalproviders which must be complied with if the provider is tomeet certification requirements.

HEALTH HISTORY

A form used by underwriters to assist in evaluating groupsor individuals to determine whether they are acceptablerisks.

HEALTH PLAN

This refers to any kind of plan that covers health careservices such as HMOs, insured plans, preferred providerorganizations, etc.

HEALTH INSURANCE (HI)

Insurance against loss by sickness or bodily injury. Thegeneric form for those forms of insurance that provide lumpsum or periodic payments in the event of loss occasioned bybodily injury, sickness or disease, and medical expense. Theterm Health Insurance is now used to replace such terms asAccident Insurance, Sickness Insurance, Medical ExpenseInsurance, Accidental Death Insurance, and DismembermentInsurance. The form is sometimes called Accident and Health,Accident and Sickness, Accident, or Disability IncomeInsurance.

HEALTH INSURANCE ASSOCIATION OF AMERICA (HIAA)

An association supported by Life and Health insurers toprovide the research, public relations, education, andlegislative base for the promotion of voluntary privateHealth Insurance.

HEALTH INSURANCE INSTITUTE (HII)

The public relations arm of the Health Insurance Associationof America. It provides for a flow of information fromHealth insurers to the public and from the public to theinsurers.

HEALTH MAINTENANCE ORGANIZATION (HMO)

An HMO is a prepaid medical service plan which providesservices to plan members. Medical providers contract withthe HMO to provide medical services to plan members. Membersmust use contracted providers. The emphasis is on preventivemedicine, and it is an alternative to employee benefitplans. Employers of more than 25 persons are required tooffer the alternative of HMO to employees, but not if thecost exceeds that of present employee benefit plans.

HEALTH SERVICE AGREEMENT (HSA)

The agreement between employer and the health plan whichoutlines a description of benefits, enrollment procedures,eligibility standards, etc.

HEALTH SERVICES

The benefits covered under a health contract.

HOSPICE

An organization which is primarily designed to provide painrelief, symptom management and supportive services for theterminally ill and their families. Hospice care is coveredunder Part A of Medicare.

HOSPITAL AFFILIATION

A contract whereby one or more hospitals agrees to providebenefits to members of a specific health plan.

HOSPITAL ALLIANCES

A group of hospitals that work together to share commonservices and thereby reduce health costs. By groupingtogether, they are better able to compete with otheralliances or chains.

HOSPITAL BENEFITS

Benefits payable for hospital room and board, plusmiscellaneous charges resulting from hospitalization.

HOSPITAL EXPENSE INSURANCE

See Hospitalization Insurance.

HOSPITAL INCOME INSURANCE

A form of insurance that provides a stated weekly or monthlypayment while the insured is hospitalized, regardless ofexpenses incurred and regardless of whether or not otherinsurance is in force. The insured can use the weekly ormonthly benefit as he chooses, for hospital or otherexpenses.

HOSPITAL INDEMNITY

Coverage that pays based on daily, weekly, or monthly limitsregardless of the amount of actual hospital expenses.Hospital Insurance (HI)Also identified as Part A of Medicare. HI provides inpatienthospital care, skilled nursing care home health and hospicecare subject to a benefit period deductible and copaymentsfor certain services.

HOSPITALIZATION EXPENSE POLICY

A policy which covers daily hospital room and board chargesand also covers miscellaneous hospital expenses (such asX-ray, etc.). It also often covers emergency treatmentcharges and many times will also include a surgical benefit.

HOSPITALIZATION INSURANCE

A form of insurance that provides reimbursement withincontractual limits for hospital and specific relatedexpenses arising from hospitalization caused by injury orsickness.

HOUSE CONFINEMENT

A provision in some Health Insurance contracts whichrequires an insured to be confined to the house in order tobe eligible for benefits. This provision is most commonlyfound in policies providing loss of income benefits.

HUNTER DISABILITY TABLES

Tables which show the probability of total and permanentdisability.

IDENTIFICATION CARD

A card given to each person covered under the plan whichidentifies him or her as being eligible for benefits.Identification of BenefitsA provision that the cost of putting a disabled insured intouch with and in the care of relatives will be reimbursed,usually up to a maximum amount.

IN-AREA SERVICES

Services which are provided within the "authorized" servicearea as designated in the plan.

INDIVIDUAL CONTRACT

A contract made with an individual that covers thatindividual and perhaps also specified members of his familyfor benefits as described in the policy.

INDIVIDUAL PRACTICE ASSOCIATION (IPA) MODEL HMO

A situation where an individual practice association iscontracted with to provide health care services. Theindividual practice association contracts with individualphysicians or groups of physicians for their services.

INFLATION FACTOR

A premium loading to provide for future increases in medicalcosts and loss payments resulting from inflation.

INFLATION PROTECTION

Provisions in a health insurance policy that increasebenefit levels to account for anticipated increases in thecost of covered services.

IN-FORCE BUSINESS

Life or Health Insurance for which premiums are being paidor for which premiums have been fully paid. The term refersto the total face amount of a Life insurer's portfolio ofbusiness. In Health Insurance it refers to the total premiumvolume of an insurer's portfolio of business.

INITIAL ELIGIBILITY PERIOD

The time period during which prospective members can applyfor coverage without providing evidence of insurability.

INSIDE LIMITS

Limits placed on hospital expense benefits which modifybenefits from the overall maximums listed in the policy. Aninside limit when applied to room and board, limits thebenefit to not only a maximum amount payable, but alsolimits the number of days the benefit will be paid.

INSURANCE IN FORCE

The annual premium payable on current contracts ofinsurance.

INTEGRATED LTC RIDER

A LTC rider which is added to a life insurance policywhereby LTC benefits paid will reduce the life insurancepolicy's benefits. LTC benefits are dependent on the lifeinsurance benefits available.

INTENTIONAL INJURY

An injury resulting from an act, the doer of which had ashis intent, inflicting injury. In an accident insurancecontract, an intentionally self-inflicted injury is notcovered (because it is not an accident). In general,intentional injuries inflicted on the insured are covered(assuming no collusion).

INTERMEDIATE CARE

A level of care associated with a skilled nursing facilitywhich provides nursing care under the supervision ofphysicians or a registered nurse. The care provided is astep down from the degree of care described as skillednursing care.

INTERMEDIATE CARE FACILITY

A facility licensed by the state, which provides nursingcare to persons who do not require the degree of care whicha hospital or skilled nursing facility provides.

INTERMEDIATE DISABILITY

See Temporary Partial Disability and Permanent PartialDisability. (H,WC)***

INTERMEDIATE REPORT

A claim report on the condition of a continuing disability.(H,WC)***

INTERNATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

An association of agents and related personnel on the HealthInsurance business.

INVALIDITY

Sickness.

LPRT

See Leading Producers Round Table.

LARGE CLAIM POOLING

A system designed to help stabilize premium fluctuations insmaller groups. Large claims (those over a stated amount)are charged to a pool contributed to by many small groupswho belong and share in that pool. The smaller the group ofgroups, the lower the pooling level. Larger groups will havea larger pooling level.

LEADING PRODUCERS ROUND TABLE (LPRT)

An organization of agents who qualify for membershipannually or on a lifetime basis by producing certain highlevels of Health Insurance premium volume in a year. It issponsored by the International Association of HealthUnderwriters.

LEGEND DRUG

A drug which has on its label "caution: federal lawprohibits dispensing without a prescription."

LENGTH OF STAY (LOS)

The total number of days a participant stays in a facilitysuch as a hospital.

LINE SLIP

A document (most commonly used at Lloyd's) which describes arisk to be insured. It is circulated by brokers, andunderwriters subscribe to it by indicating what percentageof the risk they are willing to take.

LIVING BENEFITS RIDER

A rider attached to a life insurance policy which providesLTC benefits or benefits for the terminally ill. Thebenefits provided are derived from the available lifeinsurance benefits.

LIVING NEED BENEFITS

A combination of life insurance and long-term care insurancewhich allows life insurance benefits to generate long-termcare benefits. Up to a certain percentage of the lifeinsurance policy's death benefit may be used in advance tooffset nursing home or medical expenses, reducing the faceamount of the life policy.

LONG TERM CARE (LTC)

Care which is provided for persons with chronic diseases ordisabilities. The term includes a wide range of health andsocial services provided under the supervision of medicalprofessionals.

LONG TERM CARE FACILITY

Usually a state licensed facility which provides skillednursing services, intermediate care and custodial care.

LONG-TERM DISABILITY INSURANCE

A group or individual policy which provides coverage forlonger than a short term, often until the insured reachesage 65 in the case of illness and for the remainder of hislifetime in the case of accident. See also Short-Term Disability Insurance.

LOSS-OF-INCOME BENEFITS

Benefits paid for inability to work for remuneration becauseof disability resulting from accidental bodily injury orsickness. The loss of income may be real or presumptive.

LOSS OF INCOME INSURANCE

Insurance paying loss of income benefits.

LOSS OF TIME BENEFITS

See Loss of Income Benefits.

LOSS OF TIME INSURANCE

See Loss of Income Insurance.

LONG-TERM DISABILITY INSURANCE.

SicknessIncludes physical illness, disease, pregnancy, but does notinclude mental illness.

MAINTENANCE OF EFFORT

A requirement of the Medicare catastrophic coverage act thataffects employers with plans that duplicate 50% or more ofthe new catastrophic benefits. Under MOE, they have to"maintain their effort" by providing eligibleemployees/retirees/dependents with additional benefits or a"refund" equal in value to the duplicated benefits.

MAJOR HOSPITALIZATION POLICY

The same as Major Medical Insurance, except that it appliesto expenses incurred only when the insured is hospitalized.See also Major Medical Insurance.

MAJOR MEDICAL INSURANCE

A type of Health Insurance that provides benefits up to ahigh limit for most types of medical expenses incurred,subject to a large deductible. Such contracts may containlimits on specific types of charges, like room and board,and a percentage participation clause sometimes called acoinsurance clause. These policies usually pay coveredexpenses whether an individual is in or out of the hospital.

MANAGED CARE

A system of health care where the goal is a system thatdelivers quality, cost effective health care throughmonitoring and recommending utilization of services, andcost of services.

MANAGED HEALTH CARE PLAN

A plan which involves financing, managing, and delivery ofhealth care services. Typically, it involves a group ofproviders who share the financial risk of the plan or whohave an incentive to deliver cost effective, but quality,service.

MANDATED BENEFITS

Benefits required by state or federal law.

MANDATED PROVIDERS

Types of providers of medical care whose services must beincluded by state or federal law.

MANUAL RATES

Rates based on average claims data for a large number ofgroups. These rates are then adjusted for specific groupsbased on that group's characteristics, such as the type ofindustry, changes in benefits from the standard, etc.

MARKET ASSISTANCE PLAN (MAP)

A plan promulgated by the Department of Insurance to assistbuyers to obtain certain types of insurance when they arelimited in availability.

MAXIMUM ALLOWABLE COSTS (MAC) LIST

A list of prescriptions where the reimbursement will bebased on the cost of the generic product.

MAXIMUM DISABILITY POLICY

A form of noncancellable Disability Income Insurance thatlimits an insurer's liability for any one claim but not theaggregate amount of all claims. In other words, for any oneclaim there is a maximum amount payable, but there could beany number of separate claims for different disabilities.

MAXIMUM OUT-OF-POCKET COSTS

The most a member will pay considering copayments,coinsurance, deductibles, etc.

MEDICAID

A medical benefits program administered by states andsubsidized by the federal government. Under this plan,various medical expenses will be paid to those who qualify.It is technically referred to as Title XIX Benefits.

MEDICAL CARE INSURANCE

See Medical Expense Insurance.

MEDICAL EXAMINATION

The examination of an applicant for insurance or a claimantby a physician who acts in the capacity of the insurer'sagent.

MEDICAL EXAMINER

The physician who examines an applicant or claimant onbehalf of the insurer and as an agent of the insurer.

MEDICAL EXPENSE INSURANCE

A form of Health Insurance that provides benefits formedical, surgical, and hospital expenses. This term is usedto include coverage under the names Hospital-Surgical Expense Insurance and Medical Care Insurance.

MEDICAL INFORMATION BUREAU (MIB)

A data pool service that stores coded information on thehealth histories of persons who have applied for insurancefrom subscribing companies in the past. Most Life and Healthinsurers subscribe to this bureau to get more completeunderwriting information.

MEDICAL LOSS RATIO

Total health benefits divided by total premium.

MEDICAL SUPPLIES

Any items which are essential in carrying out the treatmentof a patient's illness or injury.

MEDICALLY NECESSARY

A service or treatment which is absolutely necessary intreating a patient and which could adversely affect thepatient's condition if it were omitted.

MEDICARE

The United States federal government plan for paying certainhospital and medical expenses for persons qualifying underthe plan, usually those over 65. The hospital benefits arePart A, and the medical expense portion is Part B. Part A iscompulsory social insurance; Part B is voluntarygovernment-subsidized, government-operated insurance.

MEDICARE BENEFICIARY

Anyone entitled to Medicare benefits based on thedesignation by the Social Security Administration.

MEDICARE SUPPLEMENT INSURANCE

Insurance coverage sold on an individual or group basiswhich helps to fill the gaps in the protection provided bythe Medicare program. Medicare supplements cannot duplicateany benefits provided by Medicare, but may pay part or allof Medicare's deductibles and copayments, and may cover someservices and expenses not covered by Medicare.

MEMBER

Anyone covered under a health plan (enrollee or eligibledependent).

MEMBER CERTIFICATE

Another term for certificate of coverage.

MEMBER MONTH

The total number of participants who are members for eachmonth.

MEMBERS PER YEAR

The total number of member months divided by 12.

MENTAL HEALTH SERVICES AND SUPPLIES

Items required for treatment of mental illness, includingsubstance abuse and alcoholism.

MINIMUM PREMIUM

A cost plus arrangement whereby the employer pays theinsurer only a portion of the premium which is to be usedfor administration costs. The remainder is placed in a "bankaccount" which is then used by the insurer to pay claims.

MISCELLANEOUS EXPENSES

Ancillary expenses, usually hospital charges other thandaily room and board. Examples would be X-rays, drugs, andlab fees. The total amount of such charges that will bereimbursed is limited in most basic hospitalizationpolicies.

MODIFIED ARBITRATION PROCEDURE

Rules at Lloyd's of London providing an informal method ofresolving disputes between members and agents when the suminvolved is unlikely to exceed j10,000.

MODIFIED COMMUNITY RATING

A method of determining rates for medical services based ondata from a given geographic area.

MODIFIED FEE-FOR-SERVICE

A situation where reimbursement is made based on the actualfees subject to maximums for each procedure.

MORBIDITY

The relative incidence of disease.

MORBIDITY RATE

The ratio of the incidence of sickness to the number of wellpersons in a given group of people over a given period oftime. It may be the incidence of the number of new cases inthe given time or the total number of cases of a givendisease or disorder.

MORBIDITY TABLE

A table showing the incidence of sickness at specified agesin the same fashion that a mortality table shows theincidence of death at specified ages.

MULTI-DISCIPLINARY

Treatment which involves care provided by a wide range ofspecialists.

MULTIPLE EMPLOYER TRUST (MET)

A trust consisting of multiple small employers in the sameindustry, which is formed for the purpose of purchasinggroup health insurance or establishing a self-funded plan ata lower cost than would be available to the employersindividually.

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

Employer funds and trusts providing health care benefits toindividuals.

MULTIPLE OPTION PLAN

Under this plan, employees can optionally choose from an HMOto a PPO to a major medical plan.

NATIONAL DRUG CODE (NDC)

A system for identifying drugs.

NATIONAL FRATERNAL CONGRESS OF AMERICA

A federation of fraternal benefit societies.

NATIONAL HEALTH INSURANCE

Any system of socialized insurance benefits covering all ornearly all of the citizens of a country, established by itsfederal law, administered by its federal government, andsupported or subsidized by taxation.

NEWSPAPER POLICY.

A form of Limited Health Insurance often sold by newspapersto build or conserve circulation.

NONCANCELLABLE ("NON-CAN")

A contract of Health Insurance that the insured has a rightto continue in force by payment of premiums, as set forth inthe contract, for a substantial period of time, also as setforth in the contract. During that period of time, theinsurer has no right to make any change in any provision ofthe contract. The NAIC recommends that the term"noncancellable" not be permitted to be used to designateany form that is not renewable to at least age 50 or for atleast five years if issued after age 44. Note that this isin contrast to Guaranteed Renewable, on which the premiummay be increased by classes. The premium for noncancellablepolicies must remain as stated in the policy at the time ofissue. Contrast with Guaranteed Renewable.

NONCONFINING SICKNESS

Sickness that doe

NON-DISABLING INJURY

An injury that does not qualify the insured for total orpartial disability benefits. A Disability Income policy maycontain a provision for a small benefit in the case of suchan injury, including medical costs of up to 25% or 50% ofone month's disability benefit payment.

NONDUPLICATION OF BENEFITS

A provision in some Health Insurance policies specifyingthat benefits will not be paid for amounts reimbursed byothers. In Group Insurance, this is usually calledcoordination of benefits (COB).

NONOCCUPATIONAL INSURANCE

See Unemployment Compensation Disability Insurance.

NON-OCCUPATIONAL POLICY

A policy or provision of a policy which excludes accidentsoccurring on the job, when such employment is covered byworkers compensation.

NONPARTICIPATING PROVIDER

(1) A provider who has not signed a contract with a healthplan. (2) A medical or health care provider who is notcertified to participate in the Medicare program.Nonparticipating Provider Indemnity BenefitsCoverage where services provided by nonparticipatingproviders are reimbursed under an indemnity basis.

NONPROFIT INSURERS

Insurers organized under special state laws, usuallyexempting them from some taxes imposed on regular insurers,to supply Medical Expense Reimbursement Insurance, usuallyon a service basis. "Blue" plans (Blue Cross and BlueShield) in most states are an example.

NURSE FEES

A provision in a medical expense reimbursement policycalling for reimbursement for the fees of nurses other thanthose employed by the hospital.

NURSING HOME

A licensed facility which provides general nursing care tothose who are chronically ill or unable to take care ofnecessary daily living needs. May also be referred to as aLong Term Care facility.

OCCUPATIONAL DISEASE

Impairment of health caused by continued exposure toconditions inherent in a person's occupation or a diseasecaused by an employment or resulting from the nature of anemployment.

OFFICE VISIT

Services provided in the physician's office.

OPEN ACCESS

Allows a participant to see another participating providerof services without a referral. Also called open panel.

OPEN DEBIT.

A Life and Health Insurance debit (territory) currentlywithout an agent.

OPEN ENROLLMENT PERIOD

A period during which members can elect to come under analternate plan, usually without providing evidence ofinsurability.

OPEN PANEL

See Open Access.

OPTIONAL BENEFITS

See Elective Benefits.

OPTIONALLY RENEWABLE

A contract of Health Insurance in which an insurer reservesthe unrestricted right to terminate coverage at anyanniversary or, in some cases, at any premium due date. Itmay not do so in between.

OUTCOMES MEASUREMENT

A method of keeping track of a patient's treatment and theresponses to that treatment.

OUT-OF-AREA (OOA).

Treatment given to a member outside of the normal area.

OUT-OF-POCKET COSTS

The amounts the covered person must pay out of his or herown pocket. This includes such things as coinsurance,deductibles, etc.

OUT-OF-POCKET LIMIT

The maximum coinsurnace an individual will be required topay, after which the insurer will pay 100% of coveredexpenses up to the policy limit.

OUTPATIENT

A patient who is not a bed patient in the hospital in whichhe or she is receiving treatment.

OVERAGE INSURANCE

Health Insurance issued at ages above the usual limit, whichis generally 65.

OVERHEAD EXPENSE INSURANCE

Insurance which covers such things as rent, utilities, andemployee salaries when a business owner becomes disabled.The insurance benefit is generally not a fixed amount, butpays the amount of expenses actually incurred.

OVER-THE-COUNTER DRUGS (OTC)

A drug that can be purchased without a prescription.

PAID BUSINESS

Insurance for which the application has been signed, themedical examination completed, and the settlement for thepremium tendered.

PAID CLAIMS.

Amounts paid to providers based on the health plan.

PAID CLAIMS LOSS RATIO

Paid claims divided by total premiums.

PARTIAL DISABILITY

A condition in which, as a result of injury or sickness, theinsured cannot perform all of the duties of his occupationbut can perform some. Exact definitions vary from policy topolicy.

PARTIAL DISABILITY

See Permanent Partial Disability and Temporary PartialDisability. (G,WC,H)***

PARTIAL HOSPITALIZATION SERVICES

Additional services provided to mental health or substanceabuse patients which provides outpatient treatment as analternative or follow-up to inpatient treatment.

PARTICIPANT

An employee or former employee who is eligible to receivebenefits from an employee benefit plan or whosebeneficiaries may be eligible to receive benefits from theplan. (LI,H,PE)***

PARTICIPATING PROVIDER

A health care provider approved by Medicare to participatein the program and receive benefit payments directly fromcarriers or fiscal intermediaries.

PARTICIPATION

The number of employees enrolled compared to the totalnumber eligible for coverage. Many times, a minimumparticipation percentage is required.

PEER REVIEW

Review of health care provided by a medical staff withtraining equal to the staff which provided the treatment.

PEER REVIEW ORGANIZATION (PRO)

Groups of physicians who are paid by the federal governmentto conduct pre-admission, continued stay and servicesreviews provided to Medicare patients by Medicare approvedhospitals.

PERCENTAGE PARTICIPATION

A provision in a Health Insurance contract which states thatthe insurer will share losses in an agreed proportion withthe insured. An example would be an 80-20 participationwhere the insurer pays 80% and the insured pays the 20% oflosses covered under the contract. Often erroneouslyreferred to as coinsurance.

PERMANENT AND TOTAL DISABILITY

Total disability from which the insured does not recover.When used as a definition in a policy (usually a lifeinsurance policy rider), "permanent" is presumed after astated period of time, commonly six months.

PERMANENT PARTIAL DISABILITY

A condition where the injured party's earning capacity isimpaired for life, but he is able to work at reducedefficiency. (WC,H)***

PERMANENT TOTAL DISABILITY

A condition where the injured party is not able to work atany gainful employment for the remaining lifetime. (WC,H)

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE

A panel of physicians _ usually from different specialties _who advise the health plan regarding the proper use ofprescription drugs.

PHYSICAL THERAPIST

A trained medical person who provides rehabilitativeservices and therapy to help restore bodily functions suchas walking, speech, the use of limbs, etc.

PHYSICIAN CONTINGENCY RESERVE (PCR)

A portion of the claim which is deducted and withheld by thehealth plan before payment is made to the physician. Itserves as an incentive for proper quality and utilization ofhealth care. A portion of this reserve may be returned tothe physician or to pay claims where the plan needsadditional funds. It is also sometimes called "withhold."

PHYSICIAN'S CURRENT PROCEDURAL TERMINOLOGY (CPT)

This terminology includes medical services and proceduresperformed by physicians and other providers of health care.The health care industry uses it as a standard fordescribing services and procedures.

PLACE OF SERVICE

This designates where the actual health services are beingperformed, whether it be home, hospital, office, clinic,etc.

POINT-OF-SERVICE PLAN. POS PLAN

This plan allows a choice of whether to receive servicesfrom a participating or nonparticipating provider.

POOL (RISK POOL)

A separate account which includes entries for income andexpenses. It is used when a number of groups are puttogether for the purposes of combining their premium andpaying their losses.

PRACTICAL NURSE

A licensed individual who provides custodial type care suchas help in walking, bathing, feeding, etc. Practical nursesdo not administer medication or perform other medicallyrelated services.

PRE-ADMISSION AUTHORIZATION

A cost containment feature of many group medical policieswhereby the insured must contact the insurer prior to ahospitalization and receive authorization for the admission.

PRE-ADMISSION CERTIFICATION

Before being admitted as an inpatient in a hospital, certaincriteria are used to determine whether the inpatient care isnecessary.

PREEXISTING CONDITION

A physical condition that existed prior to the effectivedate of a policy. In many Health policies these are notcovered until after a stated period of time has elapsed.

PREFERRED PROVIDER ORGANIZATION (PPO)

An organization of hospitals and physicans who provide, fora set fee, services to insurance company clients. Theseproviders are listed as preferred and the insured may selectfrom any number of hospitals and physicians without beinglimited as with an HMO. Coverage is 100%, with a minimalcopayment for each office visit or hospital stay. Contrastwith Health Maintenance Organization.

PRESCRIPTION MEDICATION

A drug which can be dispensed only by prescription and whichhas been approved by the Food and Drug Administration.

PRESUMPTIVE DISABILITY

A disability involving loss of sight, hearing, speech, orany two limbs, which is presumed to be a permanent and totaldisability. In such cases, the insurer does not require theinsured to submit to periodic medical examinations to provecontinuing disability.

PREVENTIVE CARE

This type of care is best exemplified by routine physicalexaminations and immunizations. The emphasis is onpreventing illnesses before they occur.

PRIMARY CARE

Basic health care provided by doctors who are in thepractice of family care, pediatrics, and internal medicine.

PRIMARY CARE NETWORK (PCN)

This is a group of primary care physicians who provide careto those members of a particular health plan.

PRIMARY CARE PHYSICIAN

Some health insurance plans require members to select andseek treatment from a primary physican who either renderstreatment or refers the member to an appropriate specialistwithin the approved health care network.

PRIMARY COVERAGE

This is the coverage which pays expenses first, withoutconsideration whether or not there is any other coverage.See also Coordination of Benefits.

PRIOR AUTHORIZATION

A cost containment measure which provides full payment ofhealth benefits only when the hospitalization or medicaltreatment has been approved in advance.

PROBATIONARY PERIOD

A period of time between the effective date of a HealthInsurance policy, and the date coverage begins for all orcertain physical conditions.

PROFESSIONAL REVIEW ORGANIZATION

An organization of physicians which reviews services todetermine if they are medically necessary.

PRORATION OF BENEFITS

The adjustment of Health Insurance policy benefits by reasonof the existence of other insurance covering the samecontingency.

PROSPECTIVE PAYMENT SYSTEM

A system of Medicare reimbursement for Part A benefits whichbases most hospital payments on the patient's diagnosis atthe time of hospital admission.

PROSPECTIVE RESERVE

A Life or Health Insurance reserve which it is estimatedwill be sufficient to pay future claims when probable futurepremiums, interest, and survivorship benefits are added toit.

PROSPECTIVE REIMBURSEMENT

A system where hospitals or other health care providers arepaid annually according to rate of payment which have beenestablished ahead of time.

PROVIDER

Any individual or group of individuals that provide a healthcare service such as physicians, hospitals, etc.

QUALIFIED MEDICARE BENEFICIARY (QMB)

This is a person whose income is below the federal povertyguidelines. In these cases, the state is required to pay theMedicare Part B premiums, plus any deductibles orcopayments.

QUALIFYING EVENT

An occurrence (such as death, termination of employment,divorce, etc.) that triggers an insured's protection underCOBRA, which requires continuation of benefits under a groupinsurance plan for former employees and their families whowould otherwise lose health care coverage.

QUALITY ASSURANCE

Activities involving a review of quality of services and thetaking of any corrective actions to remove any deficiencies.

QUARANTINE BENEFIT

A benefit paid for loss of time resulting from thequarantining of an insured by health authorities.

QUARANTINE INDEMNITY

ee Quarantine Benefit.

RHU

Registered Health Underwriter.

RAILROAD RETIREMENT

system which provides retirement and other benefits,including eligibility for Medicare, for railroad workers.

RAILROAD TRAVEL POLICY

form of Accident Insurance policy sold in railroad stationsby ticket agents or by vending machines. See also TravelAccident Insurance.

RATING PROCESS

The steps used to determine a premium rate for a particulargroup based on the amount of risk that group presents. Itemsthat generally go into the rating process include age, sex,type of industry, benefits, and administrative costs.

REASONABLE AND CUSTOMARY CHARGES

The charge for medical services which refers to the amountapproved by the Medicare Carrier for payment. Customarycharges are those which are most often made by a providerfor services rendered in that particular area.

RECIDIVISM

This term refers to how often a patient returns to aninpatient hospital status for the same reason.

RECIPIENT

Anyone designated by Medicaid as being eligible to receiveMedicaid benefits.

RECURRING CLAUSE.

Health Insurance policy provision defining the duration of aperiod of time during which the recurrence of a conditionwill be considered a continuation of a prior period ofdisability or confinement.

REFERRAL

Occurs when a physician or other health plan providerreceives permission to consult another physician orhospital.

REFERRAL PROVIDER

The person or provider to whom a participating provider hasreferred a member of the plan.

REGISTERED NURSE (RN)

A licensed professional with a four-year nursing degree.Able to provide all levels of nursing care including theadminstration of medication.

REHABILITATION CLAUSE

A clause in a Health Insurance policy, particularly aDisability Income policy, that is intended to assist thedisabled policyholder in vocational rehabilitation.

RELATIVE VALUE SCHEDULE

A surgical schedule which basically compares the value ofone surgical procedure to another and establishes thesurgical fee to be paid.

RELATIVE VALUE UNIT

Sometimes used instead of dollar amounts in a surgicalschedule, this number is multiplied by a conversion factorto arrive at the surgical benefit to be paid.

RESIDUAL DISABILITY

That form of disability which becomes defined as partialdisability when an insured has returned to work immediatelyfollowing a period of total disability.

RESIDUAL INCOME

A clause used with disability income policies that providesfor benefits to be paid when the insured can do some but notall of his/her normal duties. For example, if the insuredsuffers a disability that causes him or her to lose a thirdof his or her earning power, the residual diasability clausewould provide one-third of the benefit that the policy wouldprovide for total disability.

RESOURCE BASED RELATIVE VALUE SCALE (RBRVS)

This is a classification system which is used to determinehow physicians will be compensated for services providedunder Medicare benefits.

RESPITE CARE

Normally associated with Hospice care, respite care is abenefit to family members of a patient whereby the family isprovided with a break or respite from caring for thepatient. The patient is confined to a nursing home forneeded care for a short period of time.

RESTORATION OF BENEFITS

A provision in many Major Medical Plans which restores aperson's lifetime maximum benefit amount in small incrementsafter a claim has been paid. Usually, only a small amount($1,000 to $3,000) may be restored annually.

RETENTION

The portion of the premium which is used by the insurancecompany for administrative costs.

RETROSPECTIVE RATE DERIVATION (RETRO)

A rating system whereby the employer becomes responsible fora portion of the group's health care costs. If health carecosts are less than the portion the employer agrees toassume, the insurance company may be required to refund aportion of the premium.

RETURN OF PREMIUM

A rider or provision in a Health Insurance policy agreeingto pay a benefit equal to the sum of all the premiums paid,minus claims paid, if claims over a stated period of time donot exceed a fixed percentage of the premiums paid. (H)3

REVENUE

The same as Premium.

RISK ANALYSIS

The process of determining what benefits to offer andpremium to charge a particular group.

RISK CONTROL INSURANCE

See Reinsurance.

RISK POOL

See Pool.

SNF

Skilled Nursing Facility.

SCHEDULE (SURGICAL)

A list of specified amounts payable for surgical procedures,dismemberments, ancillary expenses, and the like in hospitaland medical reimbursement policies.

SECOND SURGICAL OPINION

A cost containment technique to help patients and insurancecompanies determine whether a recommended procedure isnecessary, or whether an alternative method of treatmentcould accomplish the same result. Some health policiesrequire a second surgical opinion before specifiedprocedures will be covered, and many policies pay for thesecond opinion.

SECONDARY CARE

Medical services provided by physicians who do not havefirst contact with patients. Examples would be specialistssuch as urologists, cardiologists, etc. See also PrimaryCare and Tertiary Care.

SECONDARY COVERAGE

Coverage which provides payment for charges not covered bythe primary policy or plan. See also Coordination ofBenefits.

SECTION 125 PLAN

A plan which provides flexible benefits. This plan qualifiesunder the IRS code which allows employee contributions tomeet with pre-tax dollars.

SELF-FUNDED PLAN

Plan of insurance where an employer, which has fairlypredictable claim costs, pays the claims rather than aninsurance company. See also Administrative Services Only.

SELF-INFLICTED INJURY

An injury to the body of the insured inflicted by himself.

SERVICE AREA

The area, allowed by state agencies or by the certificationof authority, in which a health plan can provide services.

SERVICE BENEFITS

Medical expense benefits provided by service associationswhereby benefits are identified in terms of days of coverageinstead of monetary values.

SERVICE PLANS

Plans of insurance where benefits are the actual servicesrendered rather than a monetary benefit. See Blue Cross andBlue Shield.

SHORT-TERM DISABILITY INCOME POLICY

A disability income policy with benefits payable for "ShortTerm," usually less than two years, as opposed to a LongTerm Disability Income policy.

SHORT-TERM DISABILITY INSURANCE

A group or individual policy usually written to coverdisabilities of 13 or 26 weeks duration, though coverage foras long as two years is not uncommon. Contrast with

SICKNESS INSURANCE.

A form of Health Insurance against loss by illness ordisease. It does not include accidental bodily injury.

SINGLE CARRIER REPLACEMENT

A situation where one carrier replaces several othercarriers who had been providing services.

SKILLED NURSING CARE

Daily nursing and rehabilitative care that is performed onlyby or under the supervision of skilled professional ortechnical personnel. Skilled care includes administeringmedication, medical diagnosis and minor surgery.

SKILLED NURSING FACILITY (SNF)

A facility designed to qualify for treatment to Medicareeligible people. Included is treatment for rehabilitationand other care such as 24-hour nursing coverage, physical,occupational, and speech therapies, etc.

SMALL GROUP POOLING

The combining into one pool of several small group business_ used especially for computing more accurate premium ratesfor members of the pool.

SOCIAL HEALTH MAINTENANCE ORGANIZATION (SHMO)

A demonstration project funded by the Health and HumanServices Department that combines the delivery of acute andlong term care with adult day care services andtransportation.

SOCIAL SECURITY TAX

A tax paid by workers and employers on wages earned. Thetaxes support the benefit programs under the Social SecuritySystem.

SPECIFIED DISEASE POLICY

See Dread Disease Policy.

SPLIT DOLLAR COVERAGE

An arrangement of Disability Income Insurance in which theemployer and employee each pay a portion of the premium. Theemployer purchases coverage for the sick pay or paiddisability leave provided as an employee benefit. Theemployee pays for disability coverage beyond what theemployer provides as a benefit.

STAFF MODEL HMO

This is an HMO where physicians are employed and allpremiums are paid to the HMO, which then compensates thephysicians on a salary and bonus arrangement.

STANDARD CLASS RATE (SCR)

This is rate which is arrived at by using a base rate perparticipant multiplied by a factor to allow for groupdemographic information.

STOP-LOSS INSURANCE

This is a type of reinsurance which can be taken out by ahealth plan or self-funded employer plan. The plan can bewritten to cover excess losses over a specified amounteither on a specific or individual basis, or on a totalbasis for the plan over a period of time such as one year.

SUBSCRIBER

This term has two meanings _ first, it refers to a person ororganization who pays the premiums, and second, the personwhose employment makes him or her eligible for membership inthe plan.

SUBSCRIBER CONTRACT

An agreement which describes the individual's benefits undera health care policy.

SUMMARY PLAN DESCRIPTION

This is a recap or summary of the benefits provided underthe plan. It is used most often with employees covered byself-funded plans.

SUPERBILL

A form that specifically lists all of the services providedby the physician. It cannot be used in place of the standardAMA form.

SUPPLEMENTAL MEDICAL INSURANCE (SMI)

Part B of Medicare is a voluntary program which generallycovers physician's services and various outpatient services.A premium is charged for electing Part B coverage.

SUPPLEMENTAL SERVICES

Additional services which can be purchased over and abovethe basic coverage of a health plan.

SURGICAL INSURANCE BENEFITS

A form of Health Insurance against loss due to surgicalexpenses.

SURGICAL SCHEDULE

Usually part of a basic medical expense plan which itemizesvarious surgical procedures and the monetary benefitallocated to each procedure.

SURGICAL SCHEDULE

See Schedule.

SURGI-CENTER

A separate facility (from a hospital) that providesoutpatient surgical services.

SWAP MATERNITY

A provision granting immediate maternity coverage in a GroupHealth Insurance plan but terminating coverage onpregnancies in progress upon termination of the plan. Theterm "swap" means providing the coverage at the beginning ofthe policy where it is not usually provided, but notproviding it after the end of the policy where it usually isprovided.

SWITCH MATERNITY

A provision for Group Health Maternity coverage on femaleemployees only when their husbands are included in the planas dependents.

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA)

This act defines the primary and secondary coverageresponsibilities of the Medicare program and also theprovisions to be used by health plans in their contractswith the HCFA (Health Care Financing Administration).

TEMPORARY DISABILITY BENEFITS (TDB)

Legislated benefits payable to employees for nonoccupationaldisabilities under TDB laws in certain states. See alsoDisability Benefits Law.

TEMPORARY PARTIAL DISABILITY

A condition where an injured party's capacity is impairedfor a time, but he is able to continue working at reducedefficiency and is expected to fully recover. (WC,H)***

TEMPORARY TOTAL DISABILITY

A condition where an injured party is unable to work at allwhile he is recovering from injury, but he is expected torecover. (WC,H)***

TEN DAY FREE LOOK

A notice, placed prominently on the face page of the policy,advising the insured of his or her right to examine a healthpolicy, and if dissatisfied return the policy within tendays for a full refund of premium and no further obligation.

TERTIARY CARE

Services provided by such providers as thoracic surgeons,intensive care units, neurosurgeons, etc.

TERMINALLY ILL

A term which refers to the status of a person who willnormally die within 6 months of a specific illness orsickness. Often refers to the terminally ill requirement forhospice care.

THERAPEUTIC ALTERNATIVES

Alternate drug products which may be different in chemicalcontent, but provide the same effect when administered topatients.

THERAPEUTIC EQUIVALENCE

Different drugs which will control a symptom or illnessexactly the same as other drugs used to control thatillness.

THIRD PARTY ADMINISTRATOR (TPA)

A firm which provides administrative services for employersand other associations having group insurance policies. TheTPA in addition to being the liaison between the employerand the insurer is also involved with certifyingeligibility, preparing reports required by the state andprocessing claims. TPA's are being used more and more withthe increase in employer self-funded plans.

THIRD-PARTY PAYOR

This refers to any organization such as Blue Cross/ BlueShield, Medicare, Medicaid, or commercial insurancecompanies which is the payor for coverages provided by ahealth plan.

TICKET POLICY

See Transportation Ticket Policy.

TIME LIMIT ON CERTAIN DEFENSES

One of the uniform individual accident and sicknessprovisions required by state law to be included in everyIndividual Health Policy. It sets a limit on the number ofyears after a policy has been in force that an insurer canuse as a defense against a claim the fact that a physicalcondition of the insured existed before the policy wasissued, but was not declared at that time.

TITLE XIX BENEFITS

See Medicaid.

TOTAL DISABILITY

A degree of disability from injury or sickness that preventsthe insured from performing the duties of any occupationfrom remuneration or profit. The definition in any givencase depends on the wording in a covering policy.

TRANSPORTATION TICKET POLICY

An accidental Death and Dismemberment and Disability Benefitpolicy issued with a common carrier ticket and limited tothe risks or travel and the duration of the trip for whichthe ticket has been purchased. The name is derived from thefact that it was originally issued in the form of an extrastub on a travel ticket.

TRAVEL ACCIDENT INSURANCE

A form of Health Insurance limiting coverage to accidentsoccurring while the insured is traveling.

TREATMENT FACILITY

Any facility, either residential or nonresidential, which isauthorized to provide treatment for mental illness orsubstance abuse.

TREND FACTOR

The factor applied to rates which allows for such changes asincreased cost of medical providers, the cost of new andexpensive medical technology, etc.

TRIAGE

A method of ranking sick or injured people according to theseverity of their sickness or injury in order to ensure thatmedical and nursing staff facilities are used mostefficiently.

TRIPLE OPTION

A plan where employees have their choice, among differenttypes of provides such as HMO, PPO, or basic indemnity plan.Usually, their choice depends on how much they want to payfor the coverage.

UCD

See Unemployment Compensation Disability Insurance.

UNALLOCATED BENEFIT

A benefit providing reimbursement of expenses up to amaximum but without any schedule of benefits as such.Unemployment Compensation Disability Insurance (UCD)Health Insurance that covers off-the-job accidents andsickness. It does not cover disability resulting from aninjury or sickness covered by Workers CompensationInsurance. See also Disability Benefits Law.

UNIFORM BILLING CODE OF 1992 (UB-92)

This code is scheduled to be implemented on October 1, 1993.It's a federal directive which states how a hospital mustprovide their patients with bills, itemizing all servicesincluded and billed on each invoice.

UNIFORM PREMIUM

A rating system that is used to calculate premiums for allinsureds with no distinctions as to age, sex or occupation.

UNIFORM PROVISIONS

A set of provisions regarding the operating conditions ofindividual Health policies developed in a model lawrecommended by the National Association of InsuranceCommissioners and required, with minor variations by almostall jurisdictions, and permitted in all jurisdictions.

URGI-CENTER

An emergency medical service center which is separate fromany other hospital or medical facility.

USUAL, CUSTOMARY, AND REASONABLE (UCR)

See Reasonable and Customary.

UTILIZATION

This refers to how much a covered group uses a particularhealth plan or program.

UTILIZATION AND REVIEW COMMITTEE

A committee composed of medical personnel whose purpose itis to monitor the health care services and supplies providedto Medicare patients.

UTILIZATION MANAGEMENT

This procedure or process utilizes a review coordinator toevaluate the necessity and appropriateness of various healthcare services.

UTILIZATION REVIEW

A cost control mechanism by which the appropriateness,necessity, and quality of health care is monitored by bothinsurers and employers.

VEBA

Voluntary employee beneficiary association.

VISION CARE COVERAGE

A health care plan usually offered only on a group basiswhich covers routine eye examinations, and which may coverall or part of the cost of eyeglasses and lenses.

VOLUNTARY EMPLOYEE BENEFICIARY ASSOCIATION (VEBA)

A trust established under IRS Code 501(c)(9) that can beused to prefund health care.

WAITING PERIOD

The period of time between the beginning of a disability andthe start of Disability Insurance benefits. Also calledElimination period.