Glossary of Insurance Terms

Assignment of Benefits - The transfer of the right for reimbursement directly to the provider of plan benefits from the insured person to a health care provider.

- Transferring rights allows the insurer to mail any benefit payment directly to the provider.
- This legal statement is usually in the initial paperwork requested by the health care provider and may be signed by the insured person or his/her legal spouse or guardian.

Authorization - Permission to provide referred or requested a service that is granted by one or more of the following:

- Health insurance plan, or
- Medical group or the hospital depending upon who is financially responsible for the requested or referred services that are to be performed.

Deductible (DED) - The amount of money, as determined by the benefit plan that a person must pay for authorized health care services before insurance payment commences. Deductibles are usually calculated on a calendar year basis, but can also be based on the anniversary date of a patient's effective date with that plan or plan year of the named insured or subscriber.

Exclusive Provider Organization (EPO) - There are two types of EPO plans.

- The current industry standard requires that a patient select a Primary Care Physician (PCP) (some patients may only have to choose a medical group) and when needed obtain authorization from that PCP to receive specialty services. A patient must stay within the contract network and only use preferred providers. There typically is a lifetime policy maximum with this type of plan. In the event a patient goes out of network (OON) they may be responsible for the entire balance that is not paid by the payer associated with the services provided.
- The other type of EPO is one where the benefits are those of a PPO but the provider panel from which members obtain care is smaller than a PPO panel.

Guarantor - The person or entity who is financially responsible for payment on a patient's account. Usually the patient is financially responsible for medical charges. A parent or legal guardian/trustee is the guarantor for patient's 18 years of age and younger. This is also the case

for patients with a decreased mental capacity.

Medicare - Medicare is a federal insurance program which primarily serves those over 65 years old and younger, disabled people and dialysis patients. Medicare is divided into two parts:

- Medicare Part A covers inpatient hospital services, nursing home care, home health care and hospice care.
- Medicare Part B helps pay the cost of doctors' services, outpatient hospital services, medical equipment and supplies and other health services and supplies.

Medicare Supplement - A supplemental private insurance policy to help cover the difference between approved medical charges and benefits paid by Medicare.

Non-Covered Services - A cost incurred by the patient when his/her insurance policy does not cover.

Out-of-Network (OON) - Services rendered by a provider which does not have a contract to offer you care. Typically, managed care plans are contracted with a panel of providers. If a patient seeks care out-of-network, they may be financially responsible for some or all of the care provided. An exception to this rule is emergency medical care.

Point of Service (POS)/Tiered Plan - Health coverage that allows the patient to utilize a variety of benefits associated with different level/tiers of coverage. The following is an explanation of the common tiered POS coverage.

- Tier 1 Level Benefits (HMO Coverage): members are assigned or chose a PCP; the PCP must manage the care. The Specialist Physician and Facility must obtain authorization for specialty services. Typically, patients are only responsible for their co-pays.
- Tier 2 Level Benefits (PPO Coverage): the patient may self-refer to any in-network-contracted provider without obtaining authorization from their PCP but authorization is often required from the insurance company. Patients are responsible for a deductible and a percentage of their medical costs.
- Tier 3 Level Benefits: coverage for medical care provided to POS members from non-contracted provider. Insurance payment amount is dependent on the benefit offered by the plan. Services may be denied by the insurance company as not covered and the patient is responsible for 100% of all charges. Typically the patient is responsible for a

larger share of the charges.

- Care provided to POS members without the required authorization from their health plan will result in the patient being financially responsible for 100% of the charges.

Preferred Provider Organization (PPO)

- Health coverage that allows the member to direct his/her own healthcare.
- A patient may self-refer within a contracted network of physicians; after paying a deductible, a patient is commonly responsible for 10% or 20% of the allowable fee.
- A patient may choose to receive treatment from a provider outside of the PPO network thereby increasing his/her deductible or out-of-pocket maximum.
- The patient may be responsible for obtaining authorization from the health plan for some services such as physical therapy and MRI services.
- There is typically a lifetime policy maximum associated with PPO coverage.

Primary Care Physician (PCP)

- The primary care physician (can be an internist, pediatrician, family physician, or OB/Gyn) is responsible for all general medical care of the patients and referrals to specialists for tertiary care when medically appropriate.
- Most HMO, EPO and POS plans require members to choose or be assigned to a primary care physician.
- The PCP is responsible for providing or authorizing all care (hospitalization, diagnostic, workups and specialty referrals) for that patient
- Depending on the type of insurance plan, a patient may not be covered for a visit to a specialist without prior approval of the primary care provider.

Prior Authorization

- A utilization control measure employed by PPO, EPO, HMO and POS plans, whereby, elective hospital admissions or other expensive medical services or procedures must be approved by the insurance company, medical group, gatekeeper or primary care physician in advance.
- Such advance approval is known as prior authorization and is based on the insurance companies determination of medical necessity, appropriateness and other pertinent

factors.

- Generally surgeries require prior authorization as do many procedures and tests done in the physician's office. A utilization review or prior authorization phone number is usually available from the insurance company to request authorization.
- For all emergency surgeries and admissions the provider must notify the insurance carrier of the patient's admission within 24 hours.

Referral - A physician's medical order for services or consultations to be provided by a specialist.

Subscriber/Member - A person who is enrolled for benefits with an insurance company.

Worker's Compensation - Insurance coverage that is provided by employers to cover employees injured on the job. This coverage is separate from regular medical coverage.