Health Insurance Glossary

Terminology to Know

Affordable Care Act (ACA): the name of the health care reform law finalized in March 2010 that allowed people to purchase their own insurance as individuals, regardless of pre-existing conditions.

Allowed Amount: the negotiated rate and maximum amount your insurance company and provider have agreed upon for a covered health care service. Your co-payments and co-insurance will be based on this amount. This may also be called “eligible expense,” “payment allowance,” or “negotiated rate.” If your provider charges more than the plan’s allowed amount, you may have to pay the difference.

Annual Limit: the amount an insurance plan will pay in total benefits over a year. Once you hit the cap, your policy will not pay again until the next year. The ACA prohibits annual limits on essential health benefits with the exception of grandfathered plans.

Balance Billing: when a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider (in-network provider) may not balance bill you for covered services. Balance billing typically occurs when a provider is out-of-network.

Benefits: the healthcare items or services covered under a health insurance plan.

Co-Payment: the amount you pay when you receive care. The co-payment amount is set by the insurance company not the doctor’s office. This can be a percentage or flat rate amount. For example, the amount you pay may be $30.00 each time with the insurance company picking up the rest of the cost.

Co-Insurance: the amount you pay after you meet the plan’s deductible. For example, an 80/20 co-insurance rate means the insurance company pays 80 percent and you pay the remaining 20 percent. Co-Insurance usually does not start until you pay an amount equal to the deductible.

Deductible: the amount you pay out-of-pocket for medical expenses before your plan pays anything for the healthcare services you received. For example, if your deductible is $1,000, your plan won’t pay their portion for a covered service until you’ve hit your $1,000 limit. Premiums do not count toward meeting your deductible.
Excluded Services: services your health insurance company or specific plan doesn’t pay for.

Exclusive Provider Organization (EPO) Plan: this plan is similar to a HMO plan in that members are required to use network doctors. However, unlike a HMO plan, it is not necessary to select a PCP, you do need to contact a PCP for specialist referrals.

Explanation Of Benefits (EOB): an EOB is created after a claim payment has been processed by your health care plan. It explains the actions taken on a claim such as the amount that will be paid, the benefit available, discounts, reasons for denying payment and the claims appeal process. EOBs are available both as a paper copy and online.

Formulary or Drug List: a list of prescription drugs your health plan covers. Generic medications are typically covered in a formulary, whereas only some brand names are not.

Flexible Benefits Plan: a benefit program that gives employees a choice between cash, life insurance, vacations, retirement plans, and childcare. Although there are usually some requirements, flexible benefit plans offer a choice for the remaining benefits.

Health Insurance: a contract that requires your health insurer to pay for a portion (or all) of your healthcare services in exchange for a premium.

Health Insurance Marketplace: website where individuals, families, and businesses based in the US can research, compare and choose a health insurance plan that’s best for them.

Health Maintenance Organization (HMO) Plan: in this plan, your Primary Care Provider (PCP) is who you want to reach out to first. If you need care outside of what your PCP can offer, they will refer you to another provider.

In-Network or Preferred Provider: a physician, healthcare provider or healthcare facility that has a contract with your plan to provide their members services at a lower cost to the insurance company.

Medical Necessity Criteria: standards used by health plans to decide whether treatments or health care supplies recommended by your mental health provider are reasonable, necessary and appropriate. If the health plan decides the treatment meets these standards then the requested care is considered medically necessary.

Network: the contract between your insurance and your healthcare provider.
Out-of-Network: a physician, healthcare provider or healthcare facility that does not have a contract with your plan. Using healthcare services that are not covered in your plan will greatly increase the amount you have to pay.

Out-of-Pocket Limit: the amount you pay out of your own pocket when treatment or service is not covered by your plan. For example, some plans do not cover laboratory tests, x-rays, or medication.

Out-of-Pocket Maximum: the highest amount of money a person will have to pay during their plan period. It includes the money spent within the deductible amount, co-insurance, co-pays. Once you reach this limit, the insurance company will pay 100% of the allowable amount of costs for all covered benefits. Out-of-pocket maximum is higher than your deductible and does not include medication costs or services that are listed as excluded within your plan language. Today most plans have separate medication and medical out-of-pocket maximums.

Point of Service (POS) Plans: this kind of plan will allow you to pay less if you use in-network doctors or services.

Preauthorization (aka: prior-authorization or pre-approval): an insurance plan may require prior approval for certain services, drugs, or equipment to consider any charges. Preauthorization is not a guarantee that the insurance plan will cover the cost of the service, however, this is generally the first step for those requiring services that are not currently in-network with their insurance plan.

Preferred Provider Organization (PPO) Plan: this plan provides the patient access to a network of preferred providers, also known as in-network doctors. This means the list of doctors have been approved by your health insurance plan. Your out-of-pocket expenses will be less if you use a provider within the plan, however if you use a doctor that is out of network, you will still receive some reimbursement. This type of plan is typically more expensive but they include a larger network of doctors, including specialty doctors.

Premium: the amount you pay monthly, quarterly or yearly for your health insurance plan. If you have insurance through the workplace, your employer may pay a portion of your premium on your behalf as part of your employee benefit package.

Provider: a physician, healthcare provider or healthcare facility licensed, certified or accredited as required by law.

Specialist: this type of provider focuses on a specific area of medicine or illness. Some specialists may not be in-network with your plan.
Superbill: A superbill is a detailed, itemized receipt given to clients by a healthcare provider when:

- The provider cannot or does not submit out-of-network claims to a client’s payer
- A client is self-pay for any reason, such as:
  - Benefits do not include medical nutrition therapy (MNT)
  - Their diagnosis is not a covered benefit
- The client does not have health insurance

A superbill may be used by clients for Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), tax purposes, or to try to obtain reimbursement from their health plan.

A superbill does not guarantee an insurance provider will reimburse the client for the services provided. The ability of a health plan member to obtain reimbursement from a health plan is dependent on individual member benefits and coverage, as well as health plan policies regarding member reimbursement.

Medicare beneficiaries are unable to submit superbills for nutrition therapy provided by an out-of-network provider. For Medicare plans, outpatient nutrition sessions are only covered for diabetes, kidney disease, and three years following a kidney transplant.

Utilization review (or utilization management): process used by insurers to decide whether the requested mental health care is medically necessary, efficient and in line with accepted medical practice. In line with accepted medical practice means that the mental health treatment or service is proven to be effective based on scientific evidence.