

Understanding Insurance Terminology

The language of healthcare used to be a whole lot simpler. Today, under managed care, new, sometimes bewildering terms seem to crop up every year. If you feel confused, don't worry. You're not alone. We've put together the following glossary of some of the most widely used managed care terms. The definitions are simple and to the point. If you'd like a fuller explanation of anything you see below, please don't hesitate to ask your healthcare provider or a member of his/her staff.

Access—your ability to see your provider—or to obtain other health services—whenever necessary.

Ancillary services—services other than your family doctor or other medical specialist. (examples: home healthcare, physical therapy, occupational therapy).

Appeal—your right to have a coverage decision by your health plan reviewed. All states require plans to submit appeals to an in-house or *internal* review board. Currently, 42 states and the District of Columbia also permit you to appeal denials to an agency outside the insurance company, once the internal process has been exhausted.

Capitation—the way some health insurers pay doctors—not on the cost or number of services we *actually* deliver—but on a fixed formula, typically some dollar amount per patient (or “covered member”) per month.

Co-payment—a flat, out-of-pocket fee (typically \$10-20) that your health plan requires your healthcare provider to collect each time you visit.

Deductible—a flat amount you must pay before your health plan will pay for any of your care.

Fee schedule—the fee determined by your health plan—and accepted contractually by your healthcare provider—for specific procedures or services. Also known as a *fee allowance*, *allowable charge*, *fee maximum*, or *capped fee*.

Health Maintenance Organization—a health plan that offers a full-range of medical services for a set, prepaid premium. In an *open-panel HMO*, you may receive non-emergency services from a specialist, without first getting approval from your primary care doctor. In a *closed-model HMO*, the doctors you see are all employees of the HMO or belong to a physician group that contracts with the HMO. You must see an “in-network” provider; services outside the network are usually not covered.

Medically necessary services—diagnostic or treatment measures that your healthcare provider believes are appropriate given your physical condition. Your health plan may refuse to pay for something, claiming it's not a medically necessary service when, in fact, they may just not cover it because it's too expensive. You have the right to appeal that decision. (See above.)

Network—the group of physicians, hospitals, and other healthcare professionals that a health plan contracts with to deliver medical services to its members. Patients receiving services from providers outside this group are said to be going “out-of-network.”

Plan Maximum—a set number of treatments or a set dollar amount that an insurance company will pay for certain types of procedures. For example, some plans will allow you to visit a chiropractor or physical therapist 20, 28, or even 40 times; some will pay 100% of the first 20 visits and 50% of the next 20; some will pay the first \$1,000 and nothing else. It's best for you to know if your plan has a maximum benefit; and how that benefit is calculated: by the visit or by the dollar amount.

Point of service plan (POS)—a health plan option that permits you to choose—at the time you need medical services—whether to go to a network doctor or an out-of-network doctor.

Pre-authorization (also called “precertification”)—the approval that your healthcare provider must get from your health plan before providing certain specialty services, usually including chiropractic care and physical therapy. Without this approval, your care may not be covered.

Preferred provider organization (PPO)—a benefit arrangement that offers you a discount for using designated doctors but that also permits you to use, at a higher fee, physicians that haven't contracted with the PPO.

Usual and customary—the measure insurers use to determine physician reimbursement for a certain service within a specific geographical area. To determine usual and customary fees, insurers look at the range of fees doctors in the area charge for the same service. If they choose to reimburse at the lower end of the range, your provider's charge *could* be higher than the “usual and customary” fee because that fee doesn't adequately cover the provider's cost of providing the service. You could be responsible for the difference between what your insurance pays and what the provider charges.

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