Glossary of Health Insurance Terms

Health insurance is full of terms you may not know. Our glossary list the most commonly used healthcare terms and definitions. This list is to help you have a better understanding of your plan. You should review your plan's benefit guide to learn more about how these terms pertain to your specific insurance coverage.

Acute Care	Medical services provided to treat an illness or injury, usually for a short time.
Ambulatory Care	A general term for care that doesn't involve admission to an inpatient hospital bed. Visits to a doctor's office are a type of ambulatory care.
Ambulatory Surgery	Surgical procedures that do not require an overnight hospital stay. Procedures can be performed in a hospital or a licensed surgical center. Also called outpatient surgery.
Ancillary Care	Diagnostic and/or supportive services such as radiology, physical therapy, or laboratory work.
Claim	A request for payment you or your doctor sends to your health insurance company when you receive healthcare services.
Co-Insurance	A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy.
Coordination of Benefits (COB)	A method for determining the order in which benefits are paid and the amounts which are payable when a patient is covered under more than one plan.
Co-Payment	A flat-dollar amount which a patient must pay when visiting a health care provider.
Deductible	The amount you have to pay out-of-pocket for expenses before the insurance company will cover the remaining costs.
Dependent	An enrolled health plan member who has coverage tied to that of the subscriber; may be a spouse, or a child of the subscriber.
Emergency Care	Medical care that is needed immediately to save your life or to prevent serious harm to your health.
Employer Group	An employer that provides medical benefits for their employees or members of an organization.
Explanation of Benefits (EOB)	A member's statement explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.
Explanation of Payment (EOP)	A provider's statement summarizing submitted clams. It list the total billed charges, paid amount to the provider for each claim submitted.
Hospice	A health care facility that provides supportive care for the terminally ill.
Hospital Outpatient Care	Care in a hospital that usually doesn't require an overnight stay.
Hospitalization	Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.
In-Network Provider	Treatment from doctors, clinics, health centers, hospitals, medical practices and other providers whom your plan has an agreement to provide care for its members.
Inpatient	A person admitted to a health care facility to receive health care services.
Insurance Effective Date	The date on which a policyholder's coverage begins.
Insured	A person who has obtained health insurance coverage under a health insurance plan.
Long Term Care	A variety of services that can help people with personal needs and activities of daily living over a period of time. Long term care can be provided at home, nursing homes, assisted living facilities.
Medical Necessary	Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

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Member	Anyone covered under a health insurance plan, whether an enrollee or eligible dependent.
Member Services	A department in a health plan company to help answer member's questions regarding benefits, claims, networks, or plan materials.
Open Enrollment	A period each year during which employees have an opportunity to change their employer-provided healthcare coverage.
Out-of-Area	Refers to the treatment given a member outside the geographical limits of his own network. The coverage generally is restricted to emergency services.
Out-of-Network Provider	A health care professional, hospital, or pharmacy that is not part of a health plan's network of preferred providers.
Outpatient Services	A patient who receives care at a medical facility but who is not admitted to the facility overnight or is admitted for 24 hours or less.
Plan	A benefit your employer, union or other group sponsor provides to you to pay for your health care services.
Preferred Provider Organization (PPO)	A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers.
Primary Care	Basic health care services, generally rendered by those who practice family medicine, pediatrics, obstetrics or internal medicine.
Primary Care Provider (PCP)	The doctor you see usually first for common health concerns and continuing care
Prior Authorization	An approval a person gets for care before he or she receives the care.
Provider Network	The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.
Referral	A written order from your primary care doctor for you to see a specialist or get certain medical services.
Self-funded plan / Self-insured plan	A health plan under which an employer or group sponsor is financially responsible for pay plan expenses, including claims made by group plan members.
Service Area	The geographic area in which an insurance company is prepared to offer health care coverage though a network of participating providers.
Skilled Nursing Facility (SNF)	An institution for convalescence or a nursing home, the skilled nursing facility provides a high level of specialized care for long-term or acute illness.
Specialist	A provider or doctor who has advanced education and clinical training in a specific area of medicine and who does not serve as a primary care physician.
Subrogation of Third Party Liability	The Plan's right to pursue the covered person's claims for medical or dental charges against the person causing injury.
Subscriber	The person whose name the health insurance policy is in.
Third-Party Administrator (TPA)	A Third Party Administrator is an organization that process claims and performs other administrative services in accordance with a service contract.
Urgent Care	Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.
Utilization Management (UM)	The management of medical services aimed to ensure that a patient receives the necessary and appropriate high-quality care in a cost-effective manner.
Utilization Review	The determination of the medical necessity and appropriateness of health services by someone other than your attending provider.
Wrap Network	A Health Care Provider Network used as a second option to a Primary Health Care Plan. This options generally used when a out-network provider is needed. Note not all plans provide this option.