

Health Insurance A-Z

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<p>ADL See Activities of Daily Living Standards. (H)</p> <p>A&H, A&S. Accident and Health Insurance, Accident and Sickness Insurance Once commonly used as generic designations for the entire field now called Health Insurance. See Health Insurance. (H)</p> <p>Accelerated Benefits Riders on life insurance policies which allow the life insurance policy's death benefits to be used to offset expenses incurred in a convalescent or nursing home facility. (H, LI)</p> <p>Access The availability of medical care to a patient. This can be determined by location, transportation, type of medical services in the area, etc. (H)</p> <p>Accident and Health Insurance (A&H) An older name for Health Insurance. See Health Insurance. (H)</p> <p>Accident and Sickness Insurance (A&S) An older name for Health Insurance. See Health Insurance. (H)</p> <p>Accident Insurance A form of insurance against loss by accidental bodily injury to the insured. (H)</p> <p>Accidental Death and Dismemberment A policy or a provision in a Disability Income policy which pays either a specified amount or a multiple of the weekly disability benefit if the insured dies, loses his or her sight, or loses two limbs as the result of an accident. A lesser amount is payable for the loss of one eye, arm, leg, hand, or foot. (H)</p> <p>Accidental Death Benefit An extra benefit which generally equals the face of the contract or principal sum, payable in addition to other benefits in the event of death as the result of an accident. See also Double Indemnity and Multiple Indemnity. (LI,H)</p> <p>Accidental Death Insurance A form that provides payment if the death of the insured results from an accident. It is often combined with Dismemberment Insurance in a form called Accidental Death and Dismemberment. See also Accidental Death and Dismemberment. (LI,H)</p> <p>Accrete A Medicare term which means the process of adding new members to a health plan. (H)</p> <p>Actively-at-work Most group health insurance policies state that if an employee is not actively at work on the day the policy goes into effect, the coverage will not begin until the employee does return to work. (H)</p> <p>Activities of Daily Living (ADL) Everyday living functions and activities performed by individuals without assistance. These functions would include mobility, dressing, personal hygiene and eating. (H)</p> <p>Activities of Daily Living (ADL) Standards</p>	<p>Used to assess the ability of an individual to live independently, measured by the ability to perform unaided such activities as eating, bathing, toiletry, dressing, and walking. ADL standards are sometimes discussed as a way to measure or define eligibility for long term care. (H)</p> <p>Actual Charge The actual amount charged by a physician for medical services rendered. (H)</p> <p>Acute Care Skilled, medically necessary care provided by medical and nursing personnel in order to restore a person to good health. (H)</p> <p>Additional Drug Benefit List Prescription drugs listed as commonly prescribed by physicians for patients' long-term use. Subject to review and change by the health plan involved. Also called drug maintenance list. (H)</p> <p>Additional Monthly Benefit Riders added to disability income policies to provide additional benefits during the first year of a claim while the insured is waiting for Social Security benefits to begin. (H)</p> <p>Adjusted Average Per Capita Cost (AAPCC) The estimated average cost of Medicare benefits established on a per county basis _ factors include age, sex, Medicaid, institutional status, disability, and end stage renal disease status. Used to determine payments to cost contractors for Medicare benefits. (H)</p> <p>Adjusted Community Rating (ACR) Community rating adjusted by factors specific to a particular group. Also known as factored rating. (H)</p> <p>Admissions/1,000 The number of hospital admissions for each 1,000 members of the health plan. (H)</p> <p>Admits The number of admissions to a hospital (including outpatient and inpatient facilities). (H)</p> <p>Adult Day Care A group program for functionally impaired adults, designed to meet health, social and functional needs in a setting away from the adult's home. (H)</p> <p>Aftercare Individualized patient services required after hospitalization or rehabilitation. (H)</p> <p>Age Change The date on which a person's age, for insurance purposes, changes. In most Life Insurance contracts this is the date midway between the insured's natural birth dates. Health insurers frequently use the age of the previous birth date for rate determinations. On the date of age change, a person's age may change to that of the last birth date, the nearer birth date, or the next birth date, depending upon the way in which the rating structure has been established by that particular insurer. (LI,H)</p> <p>Age/Sex Factor Compares the age and sex risk of medical costs of one group relative to another. An age/sex factor above 1.00</p>
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indicates higher than average risk of medical costs due to that factor. Conversely, a factor below 1.00 indicates a lower than average risk. This measurement is used in underwriting. (H)

Age/Sex Rates (ASR)

Separate rates are established for each grouping of age and sex categories. Preferred over single and family rating because the rates and premiums automatically reflect changes in the age and sex content of the group. Also sometimes called table rates. (H)

Aggregate Indemnity

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

Allied Health Personnel

Health personnel who perform duties which would otherwise have to be performed by physicians, optometrists, dentists, podiatrists, nurses, and chiropractors. Also called paramedical personnel. (H)

Allocated Benefits

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

Allowable Charge

The lesser of the actual charge, the customary charge and the prevailing charge. It is the amount on which Medicare will base its Part B payment. (H)

Allowable Costs

Charges which qualify as covered expenses. (H)

Alternative Delivery Systems

Systems which cover health care costs, other than on the usual fee-for-service basis. Could include HMOs, IPAs, PPOs, etc. (H)

Alzheimer's Disease

A progressive, irreversible disease characterized by degeneration of the brain cells and severe loss of memory causing the individual to become dysfunctional and dependent upon others for basic living needs. (H)

Ambulatory Care

Similar to outpatient treatment in that it is care which does not require hospitalization. (H)

Ambulatory Setting

Institutions such as surgery centers, clinics, or other outpatient facilities which provide health care on an outpatient basis. (H)

Ancillary

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

Ancillary Benefits

Benefits for miscellaneous hospital charges. (H)

Approved Charge

Amounts paid under Medicare as the maximum fee for a covered service. (H)

Approved Health Care Facility or Program

A facility or program which has been approved by a health care plan as described in the contract. (H)

Assignment

An authorization to pay Medicare benefits directly to the provider. Medicare payments may be assigned to participating providers only. (H)

Assignment of Benefits

A method where the person receiving the medical benefits assigns the payment of those benefits to a physician or hospital. (H)

Average Cost Per Claim

The total cost of administrative and/or medical services divided by the number of units of exposure such as costs divided by number of admissions, or cost divided by number of outpatient claims, etc. (H)

Average Length of Stay (ALOS)

The total number of patient days divided by the number of admissions and discharges during a specified period of time. This gives the average number of days in the hospital for each person admitted. (H)

Average Wholesale Price (AWP)

Under the Medicare catastrophic coverage act, payment for prescription drugs is limited to the lowest of the pharmacy's actual charge, the sum of the AWP for the drug plus an administrative allowance, or effective 1992, the 90th percentile of pharmacy charges. (H)

Base Capitation

The total amount which covers the cost of health care per person, minus any mental health or substance abuse services, pharmacy, and administrative charges. (H)

Basic Hospital Expense Insurance

Hospital coverage providing benefits for room and board and miscellaneous hospital expenses for a specified number of days during hospital confinement. (H)

Bed Days/1,000

The number of inpatient hospital days per 1,000 members of the health plan. (H)

Benefit Levels

The maximum amount a person is entitled to receive for a particular service or services as spelled out in the contract with a health plan or insurer. (H)

Benefit Package

A description of what services the insurer or health plan offers to those covered under the terms of a health insurance contract. (H)

Benefit Period

Defines the period during which a Medicare beneficiary is eligible for Part A benefits. A benefit period is 90 days which begins the day the patient is admitted to a hospital and ends when the individual has not been hospitalized for a period of 60 consecutive days. (H)

Billed Claims

The amounts submitted by a health care provider for services provided to a covered individual. (H)

Binding Receipt

See Conditional Binding Receipt. (LI,H)

Birthday Rule

One method of determining which parent's medical coverage will be primary for dependent children: the parent whose birthday falls earliest in the year will be considered as having the primary plan. (H)

Blanket Insurance

A contract of Health Insurance that covers all of a class of persons not individually identified in the contract. (H)

Blanket Medical Expense

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

Blue Cross

Blue Cross plans are nonprofit hospital expense prepayment plans designed primarily to provide benefits for hospitalization coverage, with certain restrictions on the type of accommodations to be used. (H)

Blue Plan

A generic designation for those companies, usually writing a service rather than a reimbursement contract, who are authorized to use the designation Blue Cross or Blue Shield and the insignia of either. (H)

Blue Shield

Blue Shield plans are prepayment plans offered by voluntary nonprofit organizations covering medical and surgical expenses. (H)

Board Certified

A physician or other professional who has passed an examination which certifies him or her as a specialist in a particular medical area. (H)

Board Eligible

A professional person or physician who is eligible to take a specialty examination. (H)

Business Overhead Expense

A disability income policy which indemnifies the business for certain overhead expenses incurred when the business owner is totally disabled. (H)

CCRCs

See Continuing Care Retirement Communities (CCRCs). (H)

COB

Coordination of Benefits. See Nonduplication of Benefits. (H)

COBRA

See Consolidated Omnibus Budget Reconciliation Act of 1986. (H)

Calendar Year

January 1 through December 31 of the same year. Many deductible amount provisions are on a calendar year basis under major medical plans. Also, benefits under basic hospital surgical and medical plans are usually stated as so much for each calendar year. (H)

Capitation (CAP)

A rate paid, usually monthly, to a health care provider. In return, the provider agrees to deliver the health services agreed upon to any covered person. (H)

Carrier

Usually a commercial insurer contracted by the Department of Health and Human Services to process Part B claims payments. (H)

Carrier Replacement

This refers to a situation where one carrier replaces one or more carriers. (H)

Carry Over Provision

In major medical policies, allowing an insured who has submitted no claims during the year to apply any medical expenses incurred in the last three months of the year toward the new calendar year's deductible. (H)

Case Management

The assessment of a person's long term care needs and the appropriate recommendations for care, monitoring and follow-up as to the extent and quality of services to be provided. (H)

Case Manager

A person, usually an experienced professional, who coordinates the services necessary under the case management approach. (H)

Case Mix

The number of cases requiring different needs and uses of hospital resources. (H)

Catastrophe Policy

This is an older name for Major Medical. See Major Medical. (H)

Certificate of Authority (COA)

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

Certificate of Need (CON)

Issued by a governmental body. It certifies that the proposed facility will meet the needs of those for whom it is intended. Such need might involve constructing a new health facility, offering a new or different health service, or acquiring new medical equipment. (H)

Cestui Que Vie

The person whose life measures the duration of a trust, gift, estate, or insurance contract. Thus, in Life and Health Insurance it is the person on whose life or health the policy is written, commonly called the insured, policyholder, or policy owner. (LI,H)

Chemical Dependency Services

The services required in the treatment and diagnosis of chemical dependency, alcoholism, and drug dependency. (H)

Chemical Equivalents

Drugs which contain identical amounts of the same ingredients. (H)

Christian Science Organization

A religious organization which is certified by the First Church of Christian Scientists. The organization may also be Medicare certified as a hospital or skilled nursing facility. (H)

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

Part of the Uniformed Services Health Benefits Program which supplements the medical care available for families of active, deceased, and retired military personnel. (H)

Closed Access

A situation where covered insureds must select one primary care physician. That physician is the only one allowed to refer the patient to other health care providers within the plan. Also called Closed Panel or Gatekeeper model. (H)

Closed Panel

See Closed Access. (H)

Cognitive Impairment

A deficiency in the ability to think, perceive, reason or remember resulting in loss of the ability to take care of one's daily living needs. (H)

Coinsurance Clause

A provision stating that the insured and the insurer will share all losses covered by the policy in a proportion agreed upon in advance, i.e., 80-20 would mean that the insurer would pay 80% and the insured would pay 20% of all losses. See also Percentage Participation. (H)

Commercial Policy

In Health Insurance, this term originally applied to policy forms intended for sale to individuals in commerce, as contrasted with industrial workers. Currently the term is loosely used to mean all policies that do not guarantee renewability. (H)

Community Rating

Under this rating system, the charge for insurance to all insureds depends on the medical and hospital costs in the community or area to be covered. Individual characteristics of the insureds are not considered at all. (H)

Competitive Medical Plan (CMP)

This refers to permission given by the federal government that allows an organization to write a Medicare risk contract. (H)

Composite Rate

One rate for all members of the group regardless of their status as single or members of a family. (H)

Comprehensive Major Medical

A plan of insurance which has a low deductible, high maximum benefits, and a coinsurance feature. It is a combination of basic coverage and major medical coverage which has virtually replaced separate hospital, surgical and medical policies with each having its own deductible requirements. Also see Major Medical Insurance. (H)

Concurrent Review

A case management technique which allows insurers to monitor an insured's hospital stay and to know in advance if there are any changes in the expected period of confinement and the planned release date. (H)

Conditional Binding Receipt

This is the more exact terminology for what is often called a binding receipt. It provides that if a premium accompanies an application, the coverage will be in force from the date of application or medical examination, if any, whichever is later, provided the insurer would have issued the coverage on the basis of the facts revealed on the application, medical examination and other usual sources of underwriting information. A Life and Health Insurance policy without a conditional binding receipt is not effective until it is delivered to the insured and the premium is paid. (LI,H)

Conditionally Renewable

A contract that provides that the insured may renew it to a stated date or an advanced age, subject to the right of the insurer to decline renewal only under conditions stated in the contract. (H)

Confining

A form of disability or sickness that confines the insured indoors, usually at home or in a hospital. Many policies state that coverage is afforded only if the insured is confined. (H)

Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986

Legislation providing for a continuation of group health care benefits under the group plan for a period of time when benefits would otherwise terminate. Continuation rights apply to enrolled persons and their dependents. Coverage may be continued for up to 18 months if the insured person terminates employment or is no longer eligible. Coverage may be continued for up to 36 months in nearly all other cases, such as loss of dependent eligibility because of death of the enrolled person, divorce, or attainment of the limiting age. (H)

Continuation

Allows terminated employees to continue their group health insurance coverage under certain conditions. (H)

Continuing Care Retirement Communities (CCRCs)

Residential communities set up to provide residents with easy access to health care. (H)

Contract Year

This period runs from the effective date to the expiration date of the contract. (H)

Coordination of Benefits (COB)

See Nonduplication of Benefits. (H)

Coordination of Benefits (COB)

A group policy provision which helps determine the primary carrier in situations where an insured is covered by more than one policy. This provision prevents an insured from receiving claims overpayments. (LI,H)

Copay

This is an arrangement where the covered person pays a specified amount for various services and the health care provider pays the remainder. The covered person usually must pay his or her share when the service is rendered. Similar to coinsurance, except that coinsurance is usually a percentage of certain charges where the co-payment is a dollar amount. (H)

Copay Provision

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

Copayment

See Copay. (H)

Corridor Deductible

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

Cosmetic Procedures

Procedures which improve the appearance, but are not medically necessary. (H)

Cost Contract

An agreement between a provider and the Health Care Financing Administration to provide health services to covered persons based on reasonable costs for service. (H)

Cost of Living Benefit

An optional disability benefit where the monthly benefit will be increased annually once the insured is on claim for 12 months. (H)

Cost Sharing

A situation where covered persons pay a portion of the health costs such as deductibles, coinsurance, or copayment amounts. (H)

Covered Expenses

Health care expenses incurred by an insured or covered person that qualify for reimbursement under the terms of a policy contract. (H)

Covered Person

A person who pays premiums into the contract for the benefits provided and who also meets eligibility requirements. (H)

Credentialing

This involves approving a provider based on certain criteria to provide or participate in a health plan. (H)

Credit Health Insurance

A group disability income insurance contract whereby a creditor is protected in the event of the total disability of a debtor. The policy will pay benefits equal to the monthly installment of the debtor. (H)

Credit Insurance

Insurance on a debtor in favor of a creditor to pay off the balance due on a loan in the event of the death or disability of the debtor. Liability Insurance for abnormal loss from bad debts. (LI,H)

Custodial Care

Care that is primarily for meeting personal needs such as help in bathing, dressing, eating or taking medicine. It can be provided by someone without professional medical skills or training but must be according to doctor's orders. (H)

DBL

See Disability Benefits Law. (H)

Date of Service

The date that the health service was provided. (H)

Death Spiral

The potentially destructive cycle that may occur in an indemnity plan as a result of increased HMO penetration. The process can occur if indemnity plan rates continuously escalate because healthier and younger employees choose HMOs, leaving less healthy individuals in experience-rated indemnity plans. Employer contribution strategies and HMO pricing techniques may aggravate the problem. (H)

Deductible Carryover Credit

During the last three months of a calendar year, charges incurred for health services can be used to satisfy the deductible for the following calendar year. These credits may be applied whether or not the prior calendar year's deductible had been met. (H)

Deferred Compensation Administrator

This refers to a company that provides services under a deferred compensation plan. Services may include

administration of self-insured plans, compensation planning, salary surveys, retirement planning, etc. (H)

Delete

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

Dental Insurance

A group Health Insurance contract that provides payment for certain enumerated dental services. (H)

Department of Health and Human Services

A federal department whose responsibility is primarily dealing with social service functions such as administration and supervision of the Medicare program. (H)

Dependent Coverage

Insurance coverage on the head of a family which is extended to his or her dependents, including only the lawful spouse and unmarried children who are not yet employed on a full-time basis. "Children" may be step, foster, and adopted, as well as natural. Certain age restrictions on children usually apply. (LI,H)

Designated Mental Health Provider

The organization hired by a health plan to provide mental health and substance abuse services. (H)

Detoxification

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

Diagnosis

The process of identifying a disease. (H)

Diagnosis Related Groups (DRGs)

A method of classifying inpatient hospital services. It is used as a method of determining financing to reimburse various providers for services performed. (H)

Disability Benefits Law

A state law requiring an employer to provide disability benefits to covered employees for nonoccupational injuries, in contrast to Workers Compensation, which pays for occupational injuries. These laws are currently in effect in New York, New Jersey, Rhode Island, California, and Hawaii. (H)

Disability Buy-Sell

A disability income policy used to fund a disability buy-sell agreement whereby the business interest of a disabled stockholder following the elimination period. The policy's benefits may be paid in a lump sum or in installments. (H)

Disability Income Insurance

A form of health insurance that provides periodic payments to replace income, actually or presumptively lost, when the insured is unable to work as a result of sickness or injury. (H)

Disability Insurance Training Council, Inc

The educational arm of the International Association of Health Underwriters, the Health Insurance agents' professional society. It seeks to encourage agent educational projects by local Health associations, conducts university seminars in advanced Health underwriting areas, and conducts annual seminars for home office executives in sociological social insurance and demographic trends that may affect future application of policy forms and Health Insurance. (H)

Disability, Long-Term

See Long-Term Disability. (H)

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. (H)

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 after discharge from a hospital or other inpatient treatment. (H)

Dismemberment

The loss of, or loss of use of, specified members of the body resulting from accidental bodily injury. (H)

Dismemberment Benefit

The benefits payable for various types of dismemberment. See also Accidental Death and Dismemberment and Multiple Indemnity. (H)

Dread (or Specified) Disease Policy

Coverage, usually with a high maximum limit, for all types of medical expenses arising out of diseases named in the contract. Common diseases covered are poliomyelitis, diphtheria, multiple sclerosis, spinal meningitis, and tetanus. Cancer is sometimes covered or may be added with some companies by a rider. (H)

Drug Formulary

A schedule of prescription drugs approved for use which will be covered by the plan and dispensed through participating pharmacies. (H)

Drug Price Review (DPR)

A procedure used to determine drug price maximums. It involves determining wholesale drug prices based on the American Druggist Blue Book. (H)

Drug Utilization Review (DUR)

A method for evaluating or reviewing the use of drugs in order to determine the appropriateness of the drug therapy. (H)

Dual Choice

The federal requirement that employers having 25 or more employees who are within the service area of a federally qualified HMO, who are paying at least minimum wage and offer a health plan to their employees, must offer HMO coverage as well as an indemnity plan. (H)

Duplicate Coverage Inquiry (DCI)

A request to determine whether or not other coverage exists. Used to apply the coordination of benefits provisions where two or more insurance companies are involved. (H)

Duplication of Benefits

A situation where identical or overlapping coverage exists between two or more insurance companies or service organizations. (H)

ERISA

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

Elective Benefits

Lump sum payments which the insured may generally choose in lieu of periodic payments for certain injuries, such as fractures and dislocations. (H)

Elective Indemnities

See Elective Benefits. (H)

Eligibility Date

The date that a person is eligible for benefits. (H)

Eligibility Period

(1) The period of time during which potential members of a Group Life or Health program may enroll without providing evidence of insurability. (2) The period of time under a Major Medical policy during which reimbursable expenses may be accrued. (H)

Eligibility Requirements

Requirements imposed for eligibility for coverage, usually in a group insurance or pension plan. (LI,H)

Eligible Dependent

A dependent of an insured person who is eligible for coverage according to the requirements set forth in the contract. (H)

Eligible Employee

An employee who is eligible based on the requirements as indicated in the group contract. (H)

Eligible Expenses

Expenses as defined in the health plan as being eligible for coverage. This could involve specified health services fees or "customary and reasonable charges." (H)

Eligible Person

Similar to eligible employee except it could be a contract covering people who are not employees of a specified employer. An example might be members of an association, union, etc. (H)

Elimination Period

A loosely used term, sometimes designating the probationary period, but most often designating the waiting period in a Health Insurance policy. See also Probationary Period and Waiting Period. (H)

Emergency

An injury or disease which happens suddenly and requires treatment within 24 hours. (H)

Emergency Accident Benefit

A group medical benefit which reimburses the insured for expenses incurred for emergency treatment of accidents. (H)

Emergi-Center

See Freestanding Emergency Medical Services Center. (H)

Employee Benefit Program

Benefits offered an employee at his place of work by his employer, covering such contingencies as medical expenses, disability, retirement, and death, usually paid for wholly or in part by the employer. These benefits are usually insured. (LI,H)

Employee Certificate of Insurance

The employee's evidence of participation in a group insurance plan, consisting of a brief summary of plan benefits. The employee is provided with a certificate of insurance rather than the actual insurance policy. (LI,H)

Employee Contribution

The employee's share of the premium costs. (H)

Employer Contribution

<p>The portion of the cost of a health insurance plan which is borne by the employer. (H)</p> <p>Encounter Each time a person meets with a health care provider to receive services, is a separate "encounter." (H)</p> <p>Encounters Per Member Per Year The total number of encounters per year divided by the total number of members per year. (H)</p> <p>Enrollee An eligible individual who is enrolled in a health plan _ does not include an eligible dependent. (H)</p> <p>Enrolling Unit The organization (such as an employer) that contracts for participation in a health insurance plan. (H)</p> <p>Enrollment Used to describe the total number of enrollees in a health plan. It may also be used to refer to the process of enrolling people in a health plan. (H)</p> <p>Enrollment Period The amount of time an employee has to sign up for a contributory health plan. (H)</p> <p>Entire Contract Clause A provision in an insurance contract stating that the entire agreement between the insured and the insurer is contained in the contract, including the application if it is attached, declarations, insuring agreements, exclusions, conditions and endorsements. (LI,H)</p> <p>Evidence of Coverage See Certificate of Coverage. (H)</p> <p>Evidence of Insurability The statement of information needed for the underwriting of an insurance policy. (LI,H)</p> <p>Examination The medical examination of an applicant for Life or Health insurance. (LI,H)</p> <p>Examined Business Coverage written on an applicant who has been examined and who has signed the application but has paid no premium. (LI,H)</p> <p>Examiner A physician appointed by the medical director of a Life or Health insurer to examine applicants. (LI,H)</p> <p>Excepted Period See Probationary Period. (LI,H)</p> <p>Excluded Period See Probationary Period. (H)</p> <p>Exclusive Provider Organization (EPO) A type of preferred provider organization where individual members use particular preferred providers rather than having a choice of a variety of preferred providers. EPOs are characterized by a primary physician who monitors care and makes referrals to a network of providers. (H)</p> <p>Expected Claims The estimated claims for a person or group for a contract year based usually on actuarial statistics. (H)</p> <p>Expected Morbidity The expected incidence of sickness or injury within a given group during a given period of time as shown on a morbidity table. (H)</p> <p>Expense</p>	<p>A policy's share of the company's operating costs, fees for medical examinations and inspection reports, underwriting, printing costs, commissions, advertising, agency expenses, premium taxes, salaries, rent, etc. Such costs are important in determining dividends and premium rates. (H)</p> <p>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 proven by scientific evidence to be effective, or (2) not accepted by health care professionals as being effective. (H)</p> <p>Explanation of Benefits (EOB) The statement sent to a participant in a health plan listing services, amounts paid by the plan, and total amount billed to the patient. (H)</p> <p>Explanation of Medicare Benefits A notice which is sent to the Medicare patient which provides information designed to explain how the claim is to be paid. (H)</p> <p>Extended Care Facility A facility such as a nursing home which is licensed to provide 24-hour nursing care service in accordance with state and local laws. Three levels of care may be provided--skilled, intermediate, custodial, or any combination. (H)</p> <p>Extended Coverage A provision in certain Health policies, usually Group, to allow the insured to receive benefits for specified losses sustained after the termination of coverage, such as maternity expense benefits incurred for a pregnancy in progress at the time of the termination. (H)</p> <p>Extension of Benefits A condition in the insurance policy which allows coverage to continue beyond the expiration date of the policy in the case of employees who are not actively at work or dependents who are hospitalized on that date. The extended coverage applies only where the employee or dependent is disabled as of that date and continues only until the employee returns to work or the dependent leaves the hospital. (H)</p> <p>FASB The Financial Accounting Standards Board. (H)</p> <p>Family Dependent A person entitled to coverage because he or she is: 1. The enrollee's spouse, or 2. A single dependent child of either the enrollee or the enrollee's spouse (including stepchildren or legally adopted children), and 3. A resident of the enrollee's home. (H)</p> <p>Family Expense Policy A policy which insures the medical expenses of all members of a family. (H)</p> <p>Federal Qualification Approval of any HMO made by the HCFA after conducting their evaluation of methods of doing business, documents, contracts, facilities, and systems. (H)</p> <p>Fee-for-Service Equivalency The difference between the amount a provider receives from a reimbursement system such as capitation (a flat</p>
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<p>charge per month, for instance) compared to fee-for-service reimbursement. (H)</p> <p>Fee-for-Service Reimbursement A health care system where physicians and other providers receive payment based on their billed charge for each service provided. (H)</p> <p>Fee Maximum The maximum amount available to a provider for specific health care services under a contract. (H)</p> <p>Fee Schedule A list of maximum fees for providers who are on a fee-for-service basis. (H)</p> <p>Field Underwriting The initial screening of prospective buyers of health insurance, performed by sales personnel "in the field." May also include quoting of premium rates. (H)</p> <p>Financial Accounting Standards Board (FASB) A non-governmental group that sets standards for generally accepted accounting principles. (H)</p> <p>Fiscal Intermediary A commercial insurer contracted by the Department of Health and Human Services for the purpose of processing and administering Part A Medicare claims. (H)</p> <p>501(c)(9) Trust A voluntary employee beneficiary association. (H)</p> <p>Flat Maternity Benefit A stipulated benefit in a Hospital Reimbursement policy that is paid for maternity confinement, regardless of the actual cost of the confinement. (H)</p> <p>Flexible Benefit Plan A type of program where employees can tailor their benefits to meet their own specific needs. (H)</p> <p>Formulary See Drug Formulary. (H)</p> <p>401 Trust Governed by IRS Codes, these accounts have limited use for tax-free funding of postretirement benefits. An employer's 401(h) contribution is limited to no more than 25% of total contributions to all retiree benefits, including pension benefits. Since the health liabilities for most employers are so large, a 401(h) could provide only incidental funding. (H)</p> <p>Franchise Insurance A plan for covering groups of persons with individual policies having uniform provisions, although they may differ in benefits. Individual contracts are issued to each person with individual underwriting. It is usually applied to groups too small to qualify for true group coverage, and the solicitation of cases usually takes place among an employer's work force with his consent. In Life Insurance, it is sometimes called Wholesale Insurance. Contrast with True Group Insurance. (LI,H)***</p> <p>Fraternal Insurance Insurance offered a special group of people, namely, members of a lodge or a fraternal order. Such insurance may be written on an assessment basis or on a legal reserve basis. (LI,H)***</p> <p>Free-Standing Emergency Medical Service Center</p>	<p>A facility whose primary purpose is the provision of care for emergency medical conditions. Also called emergency-center orurgi-center. (H)</p> <p>Free-Standing Outpatient Surgical Center A facility which only provides outpatient surgical services. Also called surgi-center. (H)</p> <p>Frequency The number of times a service is provided over a given time period. (H)</p> <p>Fringe Benefits See Employee Benefit Program. (LA,H)***</p> <p>Funding Level The dollar amount required to purchase a particular medical care program. Usually measured by the premium rate for an insured program, or an amount assessed for expected claim loss and related fees under a self-funded program. (H)</p> <p>Funding Methods The agreed means by which an employer pays for health coverage. (H) Future Increase Option. An option which allows the insured to increase disability income benefits at predetermined times, specified in the policy, without evidence of insurability. (H)</p> <p>GAMC See General Agents and Managers Conference. (LI,H)***</p> <p>Gatekeeper Model Under this model of HMO and PPO organizations, the primary care physician (the gatekeeper) is the initial contact for the patient for medical care and for referrals. This is also called a closed access or closed panel. (H)</p> <p>General Agent (GA) An individual appointed by a Life or Health insurer to administer its business in a given territory. He is responsible for building his own agency and service force and is compensated on a commission basis, although he possibly has some additional expense allowances. (LI,H)</p> <p>General Agents and Managers Conference An association of insurance general agents and managers affiliated with the National Association of Life Underwriters. (LI,H)</p> <p>General LTC Rider A LTC rider which is attached to a life insurance policy but stands alone or is independent of the life policy. Any LTC benefits paid do not reduce any of the life insurance benefits. (H)</p> <p>Generic Drug A drug which is exactly the same as a brand name drug and which is allowed to be produced after the brand name drug's patent has expired. It is also called a "generic equivalent." (H)</p> <p>Generic Equivalence See Generic Drug. (H)</p> <p>Grievance Procedure A procedure which allows a member of a health plan or a provider of benefits to express complaints and seek remedies. (H)</p> <p>Group</p>
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<p>Coverage of a number of individuals under one contract. The most common "group" is employees of the same employer. (H)</p> <p>Group Certificate The document provided to each member of a group plan. It shows the benefits provided under the group contract issued to the employer or other insured. (LI,H)***</p> <p>Group Contract A contract of insurance made with an employer or other entity that covers a group of persons identified by reference to their relationship to the entity buying the contract. The group contractual arrangement is generally used to cover employees of a common employer, members of a trade association or trusteeship, members of a welfare or employee benefit association, members of a labor union, or members of a professional or other association not formed only for the purpose of obtaining insurance. (LI,H)***</p> <p>Group Credit Insurance Insurance on the Life or Health of debtors of a creditor, payable for reduction or extinguishment of the debts in case of the disability or death of the debtor. (LI,H)***</p> <p>Group Disability Insurance Coverage provided for a group of individuals for loss of compensation due to accident or sickness. (H)</p> <p>Group Health Insurance The same definition as Life Insurance but with the application to Health Insurance coverages. See Group Life Insurance. (H)</p> <p>Group Model HMO A health plan where a group of physicians is reimbursed for services they provide at a negotiated rate. The HMO also contracts with hospitals for the care of the patients of the physicians who belong to the group. (H)</p> <p>Guaranteed Standard Issue (GSI) An underwriting term used to describe the fact that a group insurance contract was issued without reference to any medical underwriting. All group participants are covered regardless of health history. (H)</p> <p>HCFA Health Care Financing Administration. (H)</p> <p>HCFA 1500 A form used by providers of health services to bill their fees to health carriers. It was developed by the government agency known as Health Care Financing Administration. (H)</p> <p>HI.2 See Health Insurance and Medicare, Part A. (H)</p> <p>HIAA See Health Insurance Association of America. (H)</p> <p>HII See Health Insurance Institute. (H)</p> <p>HIQA. Health Insurance Quality Award An award granted annually by the International Association of Health Underwriters or the National Association of Life Underwriters for high persistency of Health Insurance policies written by agents. See also Persistency. (H)</p> <p>HMO See Health Maintenance Organization. (H)</p> <p>Home Health Agency</p>	<p>A certified facility approved by a health plan to provide services under contract. (H)</p> <p>Home Health Care Care received at home as part-time skilled nursing care, speech therapy, physical or occupational therapy, part-time services of home health aides or help from homemakers or choreworkers. (H)</p> <p>Home Health Services Health care services provided by a licensed home health agency in the patient's home which is a covered expense under Part A of Medicare. (H)</p> <p>Health Benefits Package The coverages offered by a health plan to an individual or group. (H)</p> <p>Health Care Financing Administration (HCFA) Part of the Department of Health and Human Services, responsible for administration of the Medicare and Medicaid programs. The HCFA establishes standards for medical providers which must be complied with if the provider is to meet certification requirements. (H)</p> <p>Health History A form used by underwriters to assist in evaluating groups or individuals to determine whether they are acceptable risks. (H)</p> <p>Health Plan This refers to any kind of plan that covers health care services such as HMOs, insured plans, preferred provider organizations, etc. (H)</p> <p>Health Insurance (HI) . Insurance against loss by sickness or bodily injury. The generic form for those forms of insurance that provide lump sum or periodic payments in the event of loss occasioned by bodily injury, sickness or disease, and medical expense. The term Health Insurance is now used to replace such terms as Accident Insurance, Sickness Insurance, Medical Expense Insurance, Accidental Death Insurance, and Dismemberment Insurance. The form is sometimes called Accident and Health, Accident and Sickness, Accident, or Disability Income Insurance. (H)</p> <p>Health Insurance Association of America (HIAA) An association supported by Life and Health insurers to provide the research, public relations, education, and legislative base for the promotion of voluntary private Health Insurance. (H)</p> <p>Health Insurance Institute (HII) The public relations arm of the Health Insurance Association of America. It provides for a flow of information from Health insurers to the public and from the public to the insurers. (H)</p> <p>Health Maintenance Organization (HMO) An HMO is a prepaid medical service plan which provides services to plan members. Medical providers contract with the HMO to provide medical services to plan members. Members must use contracted providers. The emphasis is on preventive medicine, and it is an alternative to employee benefit plans. Employers of more than 25 persons are required to offer the alternative of HMO to employees, but not if the cost exceeds that of present employee benefit plans. (H)</p> <p>Health Service Agreement (HSA)</p>
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The agreement between employer and the health plan which outlines a description of benefits, enrollment procedures, eligibility standards, etc. (H)

Health Services

The benefits covered under a health contract. (H)

Hospice

An organization which is primarily designed to provide pain relief, symptom management and supportive services for the terminally ill and their families. Hospice care is covered under Part A of Medicare. (H)

Hospital Affiliation

A contract whereby one or more hospitals agrees to provide benefits to members of a specific health plan. (H)

Hospital Alliances

A group of hospitals that work together to share common services and thereby reduce health costs. By grouping together, they are better able to compete with other alliances or chains. (H)

Hospital Benefits

Benefits payable for hospital room and board, plus miscellaneous charges resulting from hospitalization. (H)

Hospital Expense Insurance

See Hospitalization Insurance. (H)

Hospital Income Insurance

A form of insurance that provides a stated weekly or monthly payment while the insured is hospitalized, regardless of expenses incurred and regardless of whether or not other insurance is in force. The insured can use the weekly or monthly benefit as he chooses, for hospital or other expenses. (H)

Hospital Indemnity

Coverage that pays based on daily, weekly, or monthly limits regardless of the amount of actual hospital expenses. (H)

Hospital Insurance (HI)

Also identified as Part A of Medicare. HI provides inpatient hospital care, skilled nursing care home health and hospice care subject to a benefit period deductible and copayments for certain services. (H)

Hospitalization Expense Policy

A policy which covers daily hospital room and board charges and also covers miscellaneous hospital expenses (such as X-ray, etc.). It also often covers emergency treatment charges and many times will also include a surgical benefit. (H)

Hospitalization Insurance

A form of insurance that provides reimbursement within contractual limits for hospital and specific related expenses arising from hospitalization caused by injury or sickness. (H)

House Confinement

A provision in some Health Insurance contracts which requires an insured to be confined to the house in order to be eligible for benefits. This provision is most commonly found in policies providing loss of income benefits. (H)

Hunter Disability Tables

Tables which show the probability of total and permanent disability. (H)

Identification Card

A card given to each person covered under the plan which identifies him or her as being eligible for benefits. (H)

Identification of Benefits

A provision that the cost of putting a disabled insured in touch with and in the care of relatives will be reimbursed, usually up to a maximum amount. (H)

In-Area Services

Services which are provided within the "authorized" service area as designated in the plan. (H)

Individual Contract

A contract made with an individual that covers that individual and perhaps also specified members of his family for benefits as described in the policy. (H)

Individual Practice Association (IPA) Model HMO

A situation where an individual practice association is contracted with to provide health care services. The individual practice association contracts with individual physicians or groups of physicians for their services. (H)

Inflation Factor

A premium loading to provide for future increases in medical costs and loss payments resulting from inflation. (H)

Inflation Protection

Provisions in a health insurance policy that increase benefit levels to account for anticipated increases in the cost of covered services. (H)

In-Force Business

Life or Health Insurance for which premiums are being paid or for which premiums have been fully paid. The term refers to the total face amount of a Life insurer's portfolio of business. In Health Insurance it refers to the total premium volume of an insurer's portfolio of business. (L,H)***

Initial Eligibility Period

The time period during which prospective members can apply for coverage without providing evidence of insurability. (H)

Inside Limits

Limits placed on hospital expense benefits which modify benefits from the overall maximums listed in the policy. An inside limit when applied to room and board, limits the benefit to not only a maximum amount payable, but also limits the number of days the benefit will be paid. (H)

Insurance In Force

The annual premium payable on current contracts of insurance. (H)

Integrated LTC Rider

A LTC rider which is added to a life insurance policy whereby LTC benefits paid will reduce the life insurance policy's benefits. LTC benefits are dependent on the life insurance benefits available. (H)

Intentional Injury

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

Intermediate Care

<p>A level of care associated with a skilled nursing facility which provides nursing care under the supervision of physicians or a registered nurse. The care provided is a step down from the degree of care described as skilled nursing care. (H)</p>	<p>Care which is provided for persons with chronic diseases or disabilities. The term includes a wide range of health and social services provided under the supervision of medical professionals. (H)</p>
<p>Intermediate Care Facility A facility licensed by the state, which provides nursing care to persons who do not require the degree of care which a hospital or skilled nursing facility provides. (H)</p>	<p>Long Term Care Facility Usually a state licensed facility which provides skilled nursing services, intermediate care and custodial care. (H)</p>
<p>Intermediate Disability See Temporary Partial Disability and Permanent Partial Disability. (H,WC)***</p>	<p>Long-Term Disability Insurance A group or individual policy which provides coverage for longer than a short term, often until the insured reaches age 65 in the case of illness and for the remainder of his lifetime in the case of accident. See also Short-Term Disability Insurance. (H)</p>
<p>Intermediate Report A claim report on the condition of a continuing disability. (H,WC)***</p>	<p>Loss-Of-Income Benefits Benefits paid for inability to work for remuneration because of disability resulting from accidental bodily injury or sickness. The loss of income may be real or presumptive. (H)</p>
<p>International Association of Health Underwriters An association of agents and related personnel on the Health Insurance business. (H)</p>	<p>Loss of Income Insurance Insurance paying loss of income benefits. (H)</p>
<p>Invalidity Sickness. (H)</p>	<p>Loss of Time Benefits See Loss of Income Benefits. (H)</p>
<p>LPRT See Leading Producers Round Table. (H)</p>	<p>Loss of Time Insurance See Loss of Income Insurance. (H)</p>
<p>Large Claim Pooling A system designed to help stabilize premium fluctuations in smaller groups. Large claims (those over a stated amount) are charged to a pool contributed to by many small groups who belong and share in that pool. The smaller the group of groups, the lower the pooling level. Larger groups will have a larger pooling level. (H)</p>	<p>Maintenance of Effort A requirement of the Medicare catastrophic coverage act that affects employers with plans that duplicate 50% or more of the new catastrophic benefits. Under MOE, they have to "maintain their effort" by providing eligible employees/retirees/dependents with additional benefits or a "refund" equal in value to the duplicated benefits. (H)</p>
<p>Leading Producers Round Table (LPRT) An organization of agents who qualify for membership annually or on a lifetime basis by producing certain high levels of Health Insurance premium volume in a year. It is sponsored by the International Association of Health Underwriters. (H)</p>	<p>Major Hospitalization Policy The same as Major Medical Insurance, except that it applies to expenses incurred only when the insured is hospitalized. See also Major Medical Insurance. (H)</p>
<p>Legend Drug A drug which has on its label "caution: federal law prohibits dispensing without a prescription." (H)</p>	<p>Major Medical Insurance A type of Health Insurance that provides benefits up to a high limit for most types of medical expenses incurred, subject to a large deductible. Such contracts may contain limits on specific types of charges, like room and board, and a percentage participation clause sometimes called a coinsurance clause. These policies usually pay covered expenses whether an individual is in or out of the hospital. (H)</p>
<p>Length of Stay (LOS) The total number of days a participant stays in a facility such as a hospital. (H)</p>	<p>Managed Care A system of health care where the goal is a system that delivers quality, cost effective health care through monitoring and recommending utilization of services, and cost of services. (H)</p>
<p>Line Slip A document (most commonly used at Lloyd's) which describes a risk to be insured. It is circulated by brokers, and underwriters subscribe to it by indicating what percentage of the risk they are willing to take. (H)</p>	<p>Managed Health Care Plan A plan which involves financing, managing, and delivery of health care services. Typically, it involves a group of providers who share the financial risk of the plan or who have an incentive to deliver cost effective, but quality, service. (H)</p>
<p>Living Benefits Rider A rider attached to a life insurance policy which provides LTC benefits or benefits for the terminally ill. The benefits provided are derived from the available life insurance benefits. (H)</p>	<p>Mandated Benefits Benefits required by state or federal law. (H)</p>
<p>Living Need Benefits A combination of life insurance and long-term care insurance which allows life insurance benefits to generate long-term care benefits. Up to a certain percentage of the life insurance policy's death benefit may be used in advance to offset nursing home or medical expenses, reducing the face amount of the life policy. (H)</p>	<p>Mandated Providers</p>
<p>Long Term Care (LTC)</p>	

Types of providers of medical care whose services must be included by state or federal law. (H)

Manual Rates

Rates based on average claims data for a large number of groups. These rates are then adjusted for specific groups based on that group's characteristics, such as the type of industry, changes in benefits from the standard, etc. (H)

Market Assistance Plan (MAP)

A plan promulgated by the Department of Insurance to assist buyers to obtain certain types of insurance when they are limited in availability. (H)

Maximum Allowable Costs (MAC) List

A list of prescriptions where the reimbursement will be based on the cost of the generic product. (H)

Maximum Disability Policy

A form of noncancellable Disability Income Insurance that limits an insurer's liability for any one claim but not the aggregate amount of all claims. In other words, for any one claim there is a maximum amount payable, but there could be any number of separate claims for different disabilities. (H)

Maximum Out-of-Pocket Costs

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

Medicaid

A medical benefits program administered by states and subsidized 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. (H)

Medical Care Insurance

See Medical Expense Insurance. (H)

Medical Examination

The examination of an applicant for insurance or a claimant by a physician who acts in the capacity of the insurer's agent. (LI,H)***

Medical Examiner

The physician who examines an applicant or claimant on behalf of the insurer and as an agent of the insurer. (LI,H)***

Medical Expense Insurance

A form of Health Insurance that provides benefits for medical, surgical, and hospital expenses. This term is used to include coverage under the names Hospital-Surgical Expense Insurance and Medical Care Insurance. (H)

Medical Information Bureau (MIB)

A data pool service that stores coded information on the health histories of persons who have applied for insurance from subscribing companies in the past. Most Life and Health insurers subscribe to this bureau to get more complete underwriting information. (LI,H)***

Medical Loss Ratio

Total health benefits divided by total premium. (H)

Medical Supplies

Any items which are essential in carrying out the treatment of a patient's illness or injury. (H)

Medically Necessary

A service or treatment which is absolutely necessary in treating a patient and which could adversely affect the patient's condition if it were omitted. (H)

Medicare

The United States federal government plan for paying certain hospital and medical expenses for persons qualifying under the plan, usually those over 65. The hospital benefits are Part A, and the medical expense portion is Part B. Part A is compulsory social insurance; Part B is voluntary government-subsidized, government-operated insurance. (H)

Medicare Beneficiary

Anyone entitled to Medicare benefits based on the designation by the Social Security Administration. (H)

Medicare Supplement Insurance

Insurance coverage sold on an individual or group basis which helps to fill the gaps in the protection provided by the Medicare program. Medicare supplements cannot duplicate any benefits provided by Medicare, but may pay part or all of Medicare's deductibles and copayments, and may cover some services and expenses not covered by Medicare. (H)

Member

Anyone covered under a health plan (enrollee or eligible dependent). (H)

Member Certificate

Another term for certificate of coverage. (H)

Member Month

The total number of participants who are members for each month. (H)

Members Per Year

The total number of member months divided by 12. (H)

Mental Health Services and Supplies

Items required for treatment of mental illness, including substance abuse and alcoholism. (H)

Minimum Premium

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

Miscellaneous Expenses

Ancillary expenses, usually hospital charges other than daily room and board. Examples would be X-rays, drugs, and lab fees. The total amount of such charges that will be reimbursed is limited in most basic hospitalization policies. (H)

Modified Arbitration Procedure

Rules at Lloyd's of London providing an informal method of resolving disputes between members and agents when the sum involved is unlikely to exceed \$10,000. (H)

Modified Community Rating

A method of determining rates for medical services based on data from a given geographic area. (H)

Modified Fee-For-Service

A situation where reimbursement is made based on the actual fees subject to maximums for each procedure. (H)

Morbidity

The relative incidence of disease. (H)

Morbidity Rate

The ratio of the incidence of sickness to the number of well persons in a given group of people over a given period of time. It may be the incidence of the number of

new cases in the given time or the total number of cases of a given disease or disorder. (H)

Morbidity Table

A table showing the incidence of sickness at specified ages in the same fashion that a mortality table shows the incidence of death at specified ages. (H)

Multi-Disciplinary

Treatment which involves care provided by a wide range of specialists. (H)

Multiple Employer Trust (MET)

A trust consisting of multiple small employers in the same industry, which is formed for the purpose of purchasing group health insurance or establishing a self-funded plan at a lower cost than would be available to the employers individually. (H)

Multiple Employer Welfare Arrangements

Employer funds and trusts providing health care benefits to individuals. (H)

Multiple Option Plan

Under this plan, employees can optionally choose from an HMO to a PPO to a major medical plan. (H)

National Drug Code (NDC)

A system for identifying drugs. (H)

National Fraternal Congress of America

A federation of fraternal benefit societies. (LI,H)***

National Health Insurance

Any system of socialized insurance benefits covering all or nearly all of the citizens of a country, established by its federal law, administered by its federal government, and supported or subsidized by taxation. (H)

Newspaper Policy.

A form of Limited Health Insurance often sold by newspapers to build or conserve circulation. (H)

Noncancellable ("Non-Can")

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

Nonconfining Sickness

Sickness that doe

Non-disabling Injury

An injury that does not qualify the insured for total or partial disability benefits. A Disability Income policy may contain a provision for a small benefit in the case of such an injury, including medical costs of up to 25% or 50% of one month's disability benefit payment. (H)

Nonduplication of Benefits

A provision in some Health Insurance policies specifying that benefits will not be paid for amounts reimbursed by others. In Group Insurance, this is usually called coordination of benefits (COB). (H)

Nonoccupational Insurance

See Unemployment Compensation Disability Insurance. (H)

Non-Occupational Policy

A policy or provision of a policy which excludes accidents occurring on the job, when such employment is covered by workers compensation. (H)

Nonparticipating Provider

(1) A provider who has not signed a contract with a health plan. (2) A medical or health care provider who is not certified to participate in the Medicare program. (H)

Nonparticipating Provider Indemnity Benefits

Coverage where services provided by nonparticipating providers are reimbursed under an indemnity basis. (H)

Nonprofit Insurers

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

Nurse Fees

A provision in a medical expense reimbursement policy calling for reimbursement for the fees of nurses other than those employed by the hospital. (H)

Nursing Home

A licensed facility which provides general nursing care to those who are chronically ill or unable to take care of necessary daily living needs. May also be referred to as a Long Term Care facility. (H)

Occupational Disease

Impairment of health caused by continued exposure to conditions inherent in a person's occupation or a disease caused by an employment or resulting from the nature of an employment. (H)

Office Visit

Services provided in the physician's office. (H)

Open Access

Allows a participant to see another participating provider of services without a referral. Also called open panel. (H)

Open Debit.

A Life and Health Insurance debit (territory) currently without an agent. (LI,H)***

Open Enrollment Period

A period during which members can elect to come under an alternate plan, usually without providing evidence of insurability. (H)

Open Panel

See Open Access. (H)

Optional Benefits

See Elective Benefits. (H)

Optionally Renewable

A contract of Health Insurance in which an insurer reserves the unrestricted right to terminate coverage at any anniversary or, in some cases, at any premium due date. It may not do so in between. (H)

Outcomes Measurement

A method of keeping track of a patient's treatment and the responses to that treatment. (H)

Out-of-Area (OOA).

Treatment given to a member outside of the normal area. (H)	Review of health care provided by a medical staff with training equal to the staff which provided the treatment. (H)
Out-of-Pocket Costs The amounts the covered person must pay out of his or her own pocket. This includes such things as coinsurance, deductibles, etc. (H)	Peer Review Organization (PRO) Groups of physicians who are paid by the federal government to conduct pre-admission, continued stay and services reviews provided to Medicare patients by Medicare approved hospitals. (H)
Out-of-Pocket Limit The maximum coinsurance an individual will be required to pay, after which the insurer will pay 100% of covered expenses up to the policy limit. (H)	Percentage Participation A provision in a Health Insurance contract which states that the insurer will share losses in an agreed proportion with the insured. An example would be an 80-20 participation where the insurer pays 80% and the insured pays the 20% of losses covered under the contract. Often erroneously referred to as coinsurance. (H)
Outpatient A patient who is not a bed patient in the hospital in which he or she is receiving treatment. (H)	Permanent and Total Disability Total disability from which the insured does not recover. When used as a definition in a policy (usually a life insurance policy rider), "permanent" is presumed after a stated period of time, commonly six months. (H)
Overage Insurance Health Insurance issued at ages above the usual limit, which is generally 65. (H)	Permanent Partial Disability A condition where the injured party's earning capacity is impaired for life, but he is able to work at reduced efficiency. (WC,H)***
Overhead Expense Insurance Insurance which covers such things as rent, utilities, and employee salaries when a business owner becomes disabled. The insurance benefit is generally not a fixed amount, but pays the amount of expenses actually incurred. (H)	Permanent Total Disability A condition where the injured party is not able to work at any gainful employment for the remaining lifetime. (WC,H)
Over-The-Counter Drugs (OTC) A drug that can be purchased without a prescription. (H)	Pharmacy and Therapeutics (P&T) Committee A panel of physicians _ usually from different specialties _ who advise the health plan regarding the proper use of prescription drugs. (H)
Paid Business Insurance for which the application has been signed, the medical examination completed, and the settlement for the premium tendered. (LI,H)***	Physical Therapist A trained medical person who provides rehabilitative services and therapy to help restore bodily functions such as walking, speech, the use of limbs, etc. (H)
Paid Claims. Amounts paid to providers based on the health plan. (H)	Physician Contingency Reserve (PCR) A portion of the claim which is deducted and withheld by the health plan before payment is made to the physician. It serves as an incentive for proper quality and utilization of health care. A portion of this reserve may be returned to the physician or to pay claims where the plan needs additional funds. It is also sometimes called "withhold." (H)
Paid Claims Loss Ratio Paid claims divided by total premiums. (H)	Physician's Current Procedural Terminology (CPT) This terminology includes medical services and procedures performed by physicians and other providers of health care. The health care industry uses it as a standard for describing services and procedures. (H)
Partial Disability A condition in which, as a result of injury or sickness, the insured cannot perform all of the duties of his occupation but can perform some. Exact definitions vary from policy to policy. (H)	Place of Service This designates where the actual health services are being performed, whether it be home, hospital, office, clinic, etc. (H)
Partial Disability See Permanent Partial Disability and Temporary Partial Disability. (G,WC,H)***	Point-of-Service Plan. This plan allows a choice of whether to receive services from a participating or nonparticipating provider. (H)
Partial Hospitalization Services Additional services provided to mental health or substance abuse patients which provides outpatient treatment as an alternative or follow-up to inpatient treatment. (H)	Pool (Risk Pool) A separate account which includes entries for income and expenses. It is used when a number of groups are put together for the purposes of combining their premium and paying their losses. (H)
Participant An employee or former employee who is eligible to receive benefits from an employee benefit plan or whose beneficiaries may be eligible to receive benefits from the plan. (LI,H,PE)***	
Participating Provider A health care provider approved by Medicare to participate in the program and receive benefit payments directly from carriers or fiscal intermediaries. (H)	
Participation The number of employees enrolled compared to the total number eligible for coverage. Many times, a minimum participation percentage is required. (H)	
Peer Review	

Practical Nurse

A licensed individual who provides custodial type care such as help in walking, bathing, feeding, etc. Practical nurses do not administer medication or perform other medically related services. (H)

Pre-Admission Authorization

A cost containment feature of many group medical policies whereby the insured must contact the insurer prior to a hospitalization and receive authorization for the admission. (H)

Pre-Admission Certification

Before being admitted as an inpatient in a hospital, certain criteria are used to determine whether the inpatient care is necessary. (H)

Preexisting Condition

A physical condition that existed prior to the effective date of a policy. In many Health policies these are not covered until after a stated period of time has elapsed. (H)

Preferred Provider Organization (PPO)

An organization of hospitals and physicians who provide, for a set fee, services to insurance company clients. These providers are listed as preferred and the insured may select from any number of hospitals and physicians without being limited as with an HMO. Coverage is 100%, with a minimal copayment for each office visit or hospital stay. Contrast with Health Maintenance Organization. (LI,H)***

Prescription Medication

A drug which can be dispensed only by prescription and which has been approved by the Food and Drug Administration. (H)

Presumptive Disability

A disability involving loss of sight, hearing, speech, or any two limbs, which is presumed to be a permanent and total disability. In such cases, the insurer does not require the insured to submit to periodic medical examinations to prove continuing disability. (H)

Preventive Care

This type of care is best exemplified by routine physical examinations and immunizations. The emphasis is on preventing illnesses before they occur. (H)

Primary Care

Basic health care provided by doctors who are in the practice of family care, pediatrics, and internal medicine. (H)

Primary Care Network (PCN)

This is a group of primary care physicians who provide care to those members of a particular health plan. (H)

Primary Care Physician

Some health insurance plans require members to select and seek treatment from a primary physician who either renders treatment or refers the member to an appropriate specialist within the approved health care network. (H)

Primary Coverage

This is the coverage which pays expenses first, without consideration whether or not there is any other coverage. See also Coordination of Benefits. (H)

Prior Authorization

A cost containment measure which provides full payment of health benefits only when the hospitalization or medical treatment has been approved in advance. (H)

Probationary Period

A period of time between the effective date of a Health Insurance policy, and the date coverage begins for all or certain physical conditions. (H)

Professional Review Organization

An organization of physicians which reviews services to determine if they are medically necessary. (H)

Proration of Benefits

The adjustment of Health Insurance policy benefits by reason of the existence of other insurance covering the same contingency. (H)

Prospective Payment System

A system of Medicare reimbursement for Part A benefits which bases most hospital payments on the patient's diagnosis at the time of hospital admission. (H)

Prospective Reserve

A Life or Health Insurance reserve which it is estimated will be sufficient to pay future claims when probable future premiums, interest, and survivorship benefits are added to it. (LI,H)***

Prospective Reimbursement

A system where hospitals or other health care providers are paid annually according to rate of payment which have been established ahead of time. (H)

Provider

Any individual or group of individuals that provide a health care service such as physicians, hospitals, etc. (H)

Qualified Medicare Beneficiary (QMB)

This is a person whose income is below the federal poverty guidelines. In these cases, the state is required to pay the Medicare Part B premiums, plus any deductibles or copayments. (H)

Qualifying Event

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

Quality Assurance

Activities involving a review of quality of services and the taking of any corrective actions to remove any deficiencies. (H)

Quarantine Benefit

A benefit paid for loss of time resulting from the quarantining of an insured by health authorities. (H)

Quarantine Indemnity

See Quarantine Benefit. (H)

RHU

registered Health Underwriter. (H)

Railroad Retirement

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

Railroad Travel Policy

form of Accident Insurance policy sold in railroad stations by ticket agents or by vending machines. See also Travel Accident Insurance. (H)

Rating Process

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

Reasonable and Customary Charges

The charge for medical services which refers to the amount approved by the Medicare Carrier for payment. Customary charges are those which are most often made by a provider for services rendered in that particular area. (H)

Recidivism

This term refers to how often a patient returns to an inpatient hospital status for the same reason. (H)

Recipient

Anyone designated by Medicaid as being eligible to receive Medicaid benefits. (H)

Recurring Clause.

Health Insurance policy provision defining the duration of a period of time during which the recurrence of a condition will be considered a continuation of a prior period of disability or confinement. (H)

Referral

Occurs when a physician or other health plan provider receives permission to consult another physician or hospital. (H)

Referral Provider

The person or provider to whom a participating provider has referred a member of the plan. (H)

Registered Nurse (RN)

A licensed professional with a four-year nursing degree. Able to provide all levels of nursing care including the administration of medication. (H)

Rehabilitation Clause

A clause in a Health Insurance policy, particularly a Disability Income policy, that is intended to assist the disabled policyholder in vocational rehabilitation. (H)

Relative Value Schedule

A surgical schedule which basically compares the value of one surgical procedure to another and establishes the surgical fee to be paid. (H)

Relative Value Unit

Sometimes used instead of dollar amounts in a surgical schedule, this number is multiplied by a conversion factor to arrive at the surgical benefit to be paid. (H)

Residual Disability

That form of disability which becomes defined as partial disability when an insured has returned to work immediately following a period of total disability. (H)

Residual Income

A clause used with disability income policies that provides for benefits to be paid when the insured can do some but not all of his/her normal duties. For example, if the insured suffers a disability that causes him or her to lose a third of his or her earning power, the residual disability clause would provide one-third of the benefit that the policy would provide for total disability. (H)

Resource Based Relative Value Scale (RBRVS)

This is a classification system which is used to determine how physicians will be compensated for services provided under Medicare benefits. (H)

Respite Care

Normally associated with Hospice care, respite care is a benefit to family members of a patient whereby the family is provided with a break or respite from caring for the patient. The patient is confined to a nursing home for needed care for a short period of time. (H)

Restoration of Benefits

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

Retention

The portion of the premium which is used by the insurance company for administrative costs. (H)

Retrospective Rate Derivation (RETRO)

A rating system whereby the employer becomes responsible for a portion of the group's health care costs. If health care costs are less than the portion the employer agrees to assume, the insurance company may be required to refund a portion of the premium. (H)

Return of Premium

A rider or provision in a Health Insurance policy agreeing to pay a benefit equal to the sum of all the premiums paid, minus claims paid, if claims over a stated period of time do not exceed a fixed percentage of the premiums paid. (H)3

Revenue

The same as Premium. (H)

Risk Analysis

The process of determining what benefits to offer and premium to charge a particular group. (H)

Risk Control Insurance

See Reinsurance. (H)

Risk Pool

See Pool. (H)

SNF

Skilled Nursing Facility. (H)

Schedule (Surgical)

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

Second Surgical Opinion

A cost containment technique to help patients and insurance companies determine whether a recommended procedure is necessary, or whether an alternative method of treatment could accomplish the same result. Some health policies require a second surgical opinion before specified procedures will be covered, and many policies pay for the second opinion. (H)

Secondary Care

Medical services provided by physicians who do not have first contact with patients. Examples would be specialists such as urologists, cardiologists, etc. See also Primary Care and Tertiary Care. (H)

Secondary Coverage

Coverage which provides payment for charges not covered by the primary policy or plan. See also Coordination of Benefits. (H)

Section 125 Plan

A plan which provides flexible benefits. This plan qualifies under the IRS code which allows employee contributions to meet with pre-tax dollars. (H)

Self-Funded Plan

Plan of insurance where an employer, which has fairly predictable claim costs, pays the claims rather than an insurance company. See also Administrative Services Only. (LI,H)***

Self-Inflicted Injury

An injury to the body of the insured inflicted by himself. (H)

Service Area

The area, allowed by state agencies or by the certification of authority, in which a health plan can provide services. (H)

Service Benefits

Medical expense benefits provided by service associations whereby benefits are identified in terms of days of coverage instead of monetary values. (H)

Service Plans

Plans of insurance where benefits are the actual services rendered rather than a monetary benefit. See Blue Cross and Blue Shield. (H)

Short-Term Disability Income Policy

A disability income policy with benefits payable for "Short Term," usually less than two years, as opposed to a Long Term Disability Income policy. (H)

Short-Term Disability Insurance

A group or individual policy usually written to cover disabilities of 13 or 26 weeks duration, though coverage for as long as two years is not uncommon. Contrast with Long-Term Disability Insurance. (H)

Sickness

Includes physical illness, disease, pregnancy, but does not include mental illness. (H)

Sickness Insurance.

A form of Health Insurance against loss by illness or disease. It does not include accidental bodily injury. (H)

Single Carrier Replacement

A situation where one carrier replaces several other carriers who had been providing services. (H)

Skilled Nursing Care

Daily nursing and rehabilitative care that is performed only by or under the supervision of skilled professional or technical personnel. Skilled care includes administering medication, medical diagnosis and minor surgery. (H)

Skilled Nursing Facility (SNF)

A facility designed to qualify for treatment to Medicare eligible people. Included is treatment for rehabilitation and other care such as 24-hour nursing coverage, physical, occupational, and speech therapies, etc. (H)

Small Group Pooling

The combining into one pool of several small group business _ used especially for computing more accurate premium rates for members of the pool. (H)

Social Health Maintenance Organization (SHMO)

A demonstration project funded by the Health and Human Services Department that combines the delivery of acute and long term care with adult day care services and transportation. (H)

Social Security Tax

A tax paid by workers and employers on wages earned. The taxes support the benefit programs under the Social Security System. (H)

Specified Disease Policy

See Dread Disease Policy. (H)

Split Dollar Coverage

An arrangement of Disability Income Insurance in which the employer and employee each pay a portion of the premium. The employer purchases coverage for the sick pay or paid disability leave provided as an employee benefit. The employee pays for disability coverage beyond what the employer provides as a benefit. (H)

Staff Model HMO

This is an HMO where physicians are employed and all premiums are paid to the HMO, which then compensates the physicians on a salary and bonus arrangement. (H)

Standard Class Rate (SCR)

This is rate which is arrived at by using a base rate per participant multiplied by a factor to allow for group demographic information. (H)

Stop-Loss Insurance

This is a type of reinsurance which can be taken out by a health plan or self-funded employer plan. The plan can be written to cover excess losses over a specified amount either on a specific or individual basis, or on a total basis for the plan over a period of time such as one year. (H)

Subscriber

This term has two meanings _ first, it refers to a person or organization who pays the premiums, and second, the person whose employment makes him or her eligible for membership in the plan. (H)

Subscriber Contract

An agreement which describes the individual's benefits under a health care policy. (H)

Summary Plan Description

This is a recap or summary of the benefits provided under the plan. It is used most often with employees covered by self-funded plans. (H)

Superbill

A form that specifically lists all of the services provided by the physician. It cannot be used in place of the standard AMA form. (H)

Supplemental Medical Insurance (SMI)

Part B of Medicare is a voluntary program which generally covers physician's services and various outpatient services. A premium is charged for electing Part B coverage. (H)

Supplemental Services

Additional services which can be purchased over and above the basic coverage of a health plan. (H)

Surgical Insurance Benefits

A form of Health Insurance against loss due to surgical expenses. (H)

Surgical Schedule

Usually part of a basic medical expense plan which itemizes various surgical procedures and the monetary benefit allocated to each procedure. (H)

Surgical Schedule

See Schedule. (H)

Surgi-Center

A separate facility (from a hospital) that provides outpatient surgical services. (H)

Swap Maternity

A provision granting immediate maternity coverage in a Group Health Insurance plan but terminating coverage on pregnancies in progress upon termination of the plan. The term "swap" means providing the coverage at the beginning of the policy where it is not usually provided, but not providing it after the end of the policy where it usually is provided. (H)

Switch Maternity

A provision for Group Health Maternity coverage on female employees only when their husbands are included in the plan as dependents. (H)

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

This act defines the primary and secondary coverage responsibilities of the Medicare program and also the provisions to be used by health plans in their contracts with the HCFA (Health Care Financing Administration). (H)

Temporary Disability Benefits (TDB)

Legislated benefits payable to employees for nonoccupational disabilities under TDB laws in certain states. See also Disability Benefits Law. (H)

Temporary Partial Disability

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

Temporary Total Disability

A condition where an injured party is unable to work at all while he is recovering from injury, but he is expected to recover. (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 health policy, and if dissatisfied return the policy within ten days for a full refund of premium and no further obligation. (H)

Tertiary Care

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

Terminally Ill

A term which refers to the status of a person who will normally die within 6 months of a specific illness or sickness. Often refers to the terminally ill requirement for hospice care. (H)

Therapeutic Alternatives

Alternate drug products which may be different in chemical content, but provide the same effect when administered to patients. (H)

Therapeutic Equivalence

Different drugs which will control a symptom or illness exactly the same as other drugs used to control that illness. (H)

Third Party Administrator (TPA)

A firm which provides administrative services for employers and other associations having group insurance policies. The TPA in addition to being the liaison between the employer and the insurer is also involved with certifying eligibility, preparing reports required by the state and processing claims. TPAs are being used more and more with the increase in employer self-funded plans. (LI,H)***

Third-Party Payor

This refers to any organization such as Blue Cross/ Blue Shield, Medicare, Medicaid, or commercial insurance companies which is the payor for coverages provided by a health plan. (H)

Ticket Policy

See Transportation Ticket Policy. (H)

Time Limit on Certain Defenses

One of the uniform individual accident and sickness provisions required by state law to be included in every Individual Health Policy. It sets a limit on the number of years after a policy has been in force that an insurer can use as a defense against a claim the fact that a physical condition of the insured existed before the policy was issued, but was not declared at that time. (H)

Title XIX Benefits

See Medicaid. (H)

Total Disability

A degree of disability from injury or sickness that prevents the insured from performing the duties of any occupation from remuneration or profit. The definition in any given case depends on the wording in a covering policy. (H)

Transportation Ticket Policy

An accidental Death and Dismemberment and Disability Benefit policy issued with a common carrier ticket and limited to the risks of travel and the duration of the trip for which the ticket has been purchased. The name is derived from the fact that it was originally issued in the form of an extra stub on a travel ticket. (H)

Travel Accident Insurance

A form of Health Insurance limiting coverage to accidents occurring while the insured is traveling. (H)

Treatment Facility

Any facility, either residential or nonresidential, which is authorized to provide treatment for mental illness or substance abuse. (H)

Trend Factor

The factor applied to rates which allows for such changes as increased cost of medical providers, the cost of new and expensive medical technology, etc. (H)

Triage

A method of ranking sick or injured people according to the severity of their sickness or injury in order to ensure that medical and nursing staff facilities are used most efficiently. (H)

Triple Option

A plan where employees have their choice, among different types of provides such as HMO, PPO, or basic indemnity plan. Usually, their choice depends on how much they want to pay for the coverage. (H)

UCD

See Unemployment Compensation Disability Insurance.
(H)

Unallocated Benefit

A benefit providing reimbursement of expenses up to a maximum but without any schedule of benefits as such.
(H)

Unemployment Compensation Disability Insurance (UCD)

Health Insurance that covers off-the-job accidents and sickness. It does not cover disability resulting from an injury or sickness covered by Workers Compensation Insurance. See also Disability Benefits Law. (H)

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 must provide their patients with bills, itemizing all services included and billed on each invoice. (H)

Uniform Premium

A rating system that is used to calculate premiums for all insureds with no distinctions as to age, sex or occupation.
(L,H)***

Uniform Provisions

A set of provisions regarding the operating conditions of individual Health policies developed in a model law recommended by the National Association of Insurance Commissioners and required, with minor variations by almost all jurisdictions, and permitted in all jurisdictions.
(H)

Urgi-Center

An emergency medical service center which is separate from any other hospital or medical facility. (H)

Usual, Customary, and Reasonable (UCR)

See Reasonable and Customary. (H)

Utilization

This refers to how much a covered group uses a particular health plan or program. (H)

Utilization and Review Committee

A committee composed of medical personnel whose purpose it is to monitor the health care services and supplies provided to Medicare patients. (H)

Utilization Management

This procedure or process utilizes a review coordinator to evaluate the necessity and appropriateness of various health care services. (H)

Utilization Review

A cost control mechanism by which the appropriateness, necessity, and quality of health care is monitored by both insurers and employers. (H)

VEBA

Voluntary employee beneficiary association. (H)

Vision Care Coverage

A health care plan usually offered only on a group basis which covers routine eye examinations, and which may cover all or part of the cost of eyeglasses and lenses. (H)

Voluntary Employee Beneficiary Association (VEBA)

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

Waiting Period

The period of time between the beginning of a disability and the start of Disability Insurance benefits. Also called Elimination period. (H)