Inside UP™

HEALTH BENEFITS FOR YOUR EMPLOYEES AT NO COST TO YOUR BUSINESS -LEARN HOW

It is undeniable; the structure of employee health insurance benefits is undergoing drastic changes. For many businesses, offering the same level of health insurance benefits to their employees may become much more challenging as health insurance costs continue to rise. Since health insurance benefits are highly valued by employees, many companies are turning to supplemental insurance to help fill the gaps and provide an added layer of protection for employees who wish to take advantage of it.

Offering supplemental insurance options can enable you to provide a competitive benefits package to your employees at no additional cost to your company; supplemental insurance premiums are typically paid by the employee in affordable monthly payments that are automatically deducted from their paycheck.

It is worth the time and effort to find quality supplemental insurance provided by a reputable company. You will also need to carefully consider the options available to ensure that your employees have the choices that meet their needs. This guide provides details regarding the different types of supplemental insurance available as well as tips to help you choose a good provider.

Important Facts About Supplemental Insurance

Supplemental insurance is designed to assist with expenses that are not covered by an individual's primary insurance policy. It can cover out of pocket expenses related to an illness, and can compensate for gaps in your employees' health insurance coverage.

Employers can offer supplemental options at no cost to their company. Employees choose which type of supplemental coverage they want, and the premium is taken out of their pre-tax income.
Most health insurance policies do not cover all expenses related to an illness or disability, so even with good insurance coverage, the insured person may encounter serious financial difficulties as a result of such events.

Supplemental insurance can help your employees get through a serious illness, injury, or other catastrophic event in their life without also having to deal with severe financial problems as a result. Not only can these policies cover the patient's deductible amount, but it can also provide needed cash to pay living and travel expenses, child care, or even alternative treatments not covered by the insured's basic policy.

Increased use of employee Health Savings Account programs and other consumer-driven health care plans, coupled with the fact that many people are choosing higher deductible amounts in order to make their insurance premiums more affordable, means your employees may actually be responsible for paying as much as $5,000 or more of their family's annual medical expenses.

This situation has also caused health care providers and hospitals to be extra vigilant in making sure the responsible party will be able to cover their deductible, either with cash or a supplemental insurance policy, before admitting a patient for treatment.

Benefits of Supplemental Health Insurance

Many companies are starting to offer supplemental insurance because it enables them to continue to provide an excellent benefits package to their employees despite the rising cost of basic health benefits packages. There are a number of additional benefits of offering supplemental insurance, including:

- You can offer supplemental insurance options at no cost to your business
- Your employees have the power to choose; supplemental insurance is completely optional
- Premiums are relatively low; payments are deducted from employees' pre-tax paychecks
- Having an extra layer of protection gives peace of mind and boosts morale
- Employees will save money when they are faced with an emergency
- Offsets out of pocket expenses, which have been steadily increasing
- Online tools are available to make registration easy
- Offering enhanced benefits makes your company more attractive to employees
- You can provide your employees with the same health protection as much larger companies
- Employees pay premiums with pre-tax income, so you save on FICA and FUTA taxes
- Many policies pay the insured person back for their health check-up costs
- Supplemental insurance has no deductibles
- Benefits are paid directly to the employee and their family
- Supplemental insurance premiums are refundable
- Enrollment is flexible; large and small groups are accepted
- Offering supplemental insurance requires no paperwork for your company
- Provides coverage for pre-existing conditions that many insurance companies exclude
- Can be used by new employees who are not yet eligible for health insurance coverage
- Supplemental insurance is uncomplicated; no networks, co-insurance or co-pays
- Provides an option for dental insurance that is not covered by most health plans
- Employees can keep their supplemental insurance plan even if they change jobs

Just how important are health insurance benefits to your employees? One study found that 56% of employees would prefer to have no pay increase and retain their current health insurance benefits rather than receive an increase in pay accompanied by a significant reduction in health benefits.
(Source: Harris Interactive poll conducted for the *Wall Street Journal Online*'s Health Industry Edition)

Even with good health coverage, 68% of employees of small businesses worry about paying their bills during a period of lost income due to illness or disability, and 54% are concerned about having enough money to cover premiums and out-of-pocket expenses during such times.
Are you hoping to retain high quality employees? Having a choice of voluntary benefits engenders loyalty to their company, according to 38% of small business employees surveyed.
(Source: MetLife, Inc.)

In a study of 528 U.S. employees, health care out-ranked compensation by 2 to1 as the most important job benefit. And two-thirds of the study participants cited health care coverage as the main factor in staying with or choosing an employer.
(Source: Hewitt Associates)

Disadvantages of Supplemental Insurance

The main disadvantage of supplemental insurance is one that will affect the individual employee rather than your business, and that is cost. While supplemental insurance can be had for a relatively low monthly payment, the premiums do constitute an additional expense for those employees who choose it. It is nonetheless an optional expense, and the decision ultimately lies with the individual employee, who will have to determine whether they need and can afford the extra coverage.

As with any type of insurance policy, there are some limits to the coverage provided by supplemental insurance. For example, your employees will need to completely exhaust their primary policy benefits before their supplemental coverage can take over.

The insurance laws of some states may have additional eligibility limits or enforce restrictions or delays on the introduction of supplemental policies. It is a good idea to find out about any such limits imposed by your state's laws, and also make sure that your employees understand these limits when reviewing their supplemental insurance options.

Types of Supplemental Insurance Coverage

Here are some of the more common categories of supplemental insurance:

- Critical illness insurance (also called disease-specific insurance) is designed to help with the costs associated with a serious illness such as cancer. Such a policy can provide cash to help the insured pay for expenses that are not covered by their regular health plan or disability insurance. The cash can be used to pay for deductibles, travel expenses, child care, living expenses, out-of-network specialists, and even alternative therapies.
- Basic coverage pays "first dollar" costs for employees with a high deductible on their primary health insurance policy. This type of supplemental insurance is highly valued by employees with limited resources with which to pay their deductible.
- Emergency insurance is just that; it covers emergency room visits, hospital stays, ambulance costs, and treatments for conditions such as broken teeth or concussion.
- International medical insurance covers health care while travelling abroad.
- Umbrella or catastrophic policies, also called "limit" policies, can be used to pay large deductibles and otherwise supplement your employees' basic health coverage.

Many supplemental insurance providers also offer life, vision, dental, and other types of policies, which you will want to consider when comparing providers.

Questions to Ask When Choosing a Supplemental Insurance Provider

Supplemental insurance providers are on the increase, making it that much more challenging to choose an agency to provide supplemental benefits for your employees. Here are a few questions to ask when making your comparison. The answers will help you evaluate each provider and make your final selection.

- What will be the cost to employees who choose a supplemental policy? The monthly premium for a supplemental policy can range from $20 per year to $400 per month, depending on the type of policy selected. However, most fall within the $40 to $75 per month range. The benefits of supplemental policies are very straightforward and well-defined in terms of how much they will pay, so it is easy for employees to see the correlation between cost and potential benefits when choosing a policy.

- How is policy billing handled? Find out, for example, how the company deals with missed paycheck deductions due to employee time off or other situations. You do not want your employees to be surprised by a premium bill in their mailbox, and this should not be necessary. A good agency will have options such as deferred payments or an online payment solution.
- Will your own payroll provider be able to make billing adjustments when necessary, for example, when an employee wishes to cancel their policy?
- How many billing modes are available? Some providers offer the flexibility of having weekly, bi-weekly, or monthly billing.
- How well do the supplemental policies integrate with primary insurance? Benefits from supplemental policies are paid in addition to benefits from the main policy, and benefits should be easily coordinated so that gaps are filled without duplicating coverage. Cash benefits offer the flexibility to replace lost income and to pay for other needs related to illness or disability.
- Does the carrier offer universal availability? Most supplemental insurance policies offer coverage to anyone who applies, and do not turn down applicants based on age or medical history.
- Are pre-existing medical conditions covered? This is one of the main benefits of having supplemental insurance.
- Does the provider have a toll free customer service number?
- Does the carrier pay claims promptly? This is really the most important factor when choosing a supplemental insurance provider. Check with your local insurance board for customer satisfaction ratings, and also find out if the provider has a claims committee that reviews denied claims.

Making Your Final Selection

Look for providers with substantial references from past and current clients. You should not rely solely on testimonials available on the company's website. Conduct searches on websites like Yelp, which offer customer reviews, or even on Google, which will help ensure you get honest and objective reviews.

If possible, contact someone who has worked with the company, ask questions about the services received, and gauge their satisfaction. Whenever possible, speak to a staff member who has personally dealt with the company you're inquiring about.

Once you have gathered several unbiased sources, prepare a few specific questions to ask regarding the company and how it has met their needs. Ask them to rate the provider on factors such as expertise, reliability, customer support, and communication.

Check to see if the company is highly rated by the Better Business Bureau, Standard and Poor's, A.M. Best, or other well known rating service.

How long has the provider been in business? Insurance agents and brokers often advertise low cost insurance, but it's important to do your research to be sure you're working with an established and reputable company.

Do they have experience providing supplemental insurance to businesses? Networking with other businesses like yours is a good way to get recommendations of providers with the appropriate experience.

Finally, gather quotes based on your needs. While you should not base your decision on price alone, it is an important factor.

The best way to compare prices—and to be sure you're dealing with a quality, reputable insurance provider is to obtain quotes from top, pre-screened vendors.

At InsideUp, we simplify the entire vendor selection process so you can choose with confidence. Visit InsideUp.com, select Supplemental Insurance from the dropdown menu on our home page, and we will be happy to provide highly competitive quotes based on your specific needs.

Glossary of Key Terms

Accidental injuries: unintentional internal or external injuries, e.g., strains, animal bites, burns, contusions and abrasions which result in trauma to the body. Accidental injuries are different from illness related conditions.
Acupuncture services: the treatment of a disease or condition by inserting special needles along specific nerve pathways for therapeutic purposes. The placement of the needles varies with the disease or condition being treated.

Acute care: care that is provided in an office, urgent care setting, emergency room or hospital for a medical illness, accident or injury. Acute care may be emergency, urgent or non-urgent, but is not primarily preventive in nature.

Adverse selection: a tendency for higher than average bad risks to be issued coverage, e.g., an association plan where all members are eligible for enrollment without screening. The members with pre-existing health problems rush to join while the healthiest shop around. That increases average claims cost, causing the premiums to increase, causing the healthiest to shop around even more. Eventually, the plan is unaffordable for any good risk to consider buying and the whole wishful thinking scheme bites the dust. It is abandoned and the members must look elsewhere.

Aggregate maximum: in some policies, "aggregate maximum amount means the maximum amount payable… for any one covered injury or sickness for each insured person… ". Because one major illness or major injury could exceed this aggregate amount, typically $500,000, it effectively negates the benefit of the lifetime maximum which is a higher figure.

Alternative/complimentary care: therapeutic practices that are not currently considered an integral part of conventional medical practice. Therapies are termed Complimentary when used in addition to conventional treatments and as Alternative when used instead of conventional treatment. Alternative medicine includes, but is not limited to, Chinese or Ayurvedic medicine, herbal treatments, vitamin therapy, homeopathic medicine and other non-traditional remedies for treating diseases or conditions.

Ambulance: a specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Ancillary services: services and supplies (in addition to room services) that hospitals, alcoholism treatment centers and other facilities bill for and regularly make available for the treatment of the member's condition.

Anniversary date: (i) the annual date on which a group renews its coverage and optional coverages or other choices, e.g., employee waiting periods, can be changed. Usually this is the annual anniversary of when the policy was first in effect. (ii) for some individual policies, the annual date on which certain changes may occur, e.g., policyholder can change the deductible or health insurance company changes the premium.

Appeal: a process for reconsideration of the insurer's decision regarding a member's claim.

Authorization: approval of benefits for a covered procedure or service.
Benefit period: the number of days or units of service, such as two office visits per member's benefit year, for which the insurer will provide benefits during a specified length of time.

Benefit year: A specified 12 month period. It is usually either (i) the calendar year, or (ii) from anniversary to anniversary of when the coverage came into effect.

Billed charges: a provider's regular charges for services and supplies, as offered to the public generally and without any adjustment for any applicable PPO, participating provider or other discounts.

Birth abnormality: a condition that is recognizable at birth, such as a fractured arm.

Birthday rule: the guideline that determines which of two parents' health insurance coverages is primary for the coverage of dependent child(ren). Generally, under the birthday rule, the parent whose birthday comes first during the year is considered to have the primary insurance coverage for the child(ren). Any balance may be submitted to the other parent's insurance carrier for additional consideration.

Capitation: A method used by an entity responsible for financing health care, e.g., certain health insurers and some large employers, to pay medical providers such as a group of physicians or hospitals. A pre-determined payment is made periodically to cover a number of patients for whatever medical care is needed, ie., payment is per person instead of per procedure.
The financial risk is shifted in large part to the medical providers. In addition, the insurer or self-funded plan saves money by not having to process claims. Primary care capitation covers only primary care. Partial capitation covers primary care and specialty care. Global or full capitation also includes hospitalization.

Care management: a plan of medically necessary and appropriate health care, which is aimed at promoting more effective interventions to meet member needs and optimize care. Care management is also referred to as case management.

Care manager: a professional (e.g., nurse, doctor or social worker) who works with members, providers and the insurer to coordinate services deemed medically necessary for the member. A care manager is also referred to as a case manager.

Certificate, or policy certificate: A document issued by the insurer which explains the benefits, limitations, exclusions, terms and conditions of the health coverage.

Chemotherapy: drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

Chiropractic services: a system of therapy in which disease is considered the result of abnormal function of the nervous system. This method of treatment usually involves manipulation of the spinal column and other body structures.

COBRA: an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law allows individuals, in certain cases, to continue their group health insurance coverage for a specified period after termination of their employment for other qualifying events.

Community Rating: The premium charged to a group or individual is not based on its claims alone, but is based on the claims of all the groups or individuals in a certain category, e.g, all the individuals in a county, or all the employers in a certain region or industry.

Complaint: an expression of dissatisfaction with the insurer's services or the practices of an in-network provider, whether medical or non-medical in nature.

Consultation/second opinion: a service provided by another physician who gives an opinion about the treatment of the member's condition. The consulting physician often has specialized skills that are helpful in diagnosing or treating the illness or injury.

Coordination of benefits: also known as COB, a stipulation in most health insurance policies that helps prevent duplicate payments for services covered by more than one policy or program of insurance. For example, a member may be covered by the member's own policy, as well as a spouse's policy. Eligible medical expenses are covered first by a person's own policy. Any balance is submitted to the spouse's health insurance carrier for additional consideration.

Copayment or Co-pay: the portion of a claim or medical expense that a member must pay out of the member's own pocket to a provider or a facility for each service. A copayment or co-pay is usually a fixed amount that is paid at the time the service is rendered (but sometimes is a percentage).

Usually, but not always, the health insurance company pays 100% of the balance, i.e., there is no coinsurance. Usually, but not always, the annual deductible does not have to be paid first when a co-pay applies. Sometimes there is a special deductible, e.g., for prescriptions, where an annual prescription deductible must be paid first, and then prescriptions can be paid for with a co-pay.

Cosmetic services: beautification procedures, services or surgery of a physical characteristic to improve an individual's appearance.

Cost sharing: the general term for out-of-pocket expenses, e.g., copayments and deductibles, paid by a member.

Custodial care: care provided primarily to meet the personal needs of the member. This includes help in walking, bathing or dressing. It also includes, but is not limited to, preparing food or special diets, feeding, administration of medicine that is usually self-administered or any other care which does not require continuing services of specialized medical personnel.

Deductible: an amount that is required to be paid by a subscriber before the insurer will begin to reimburse for services. However, if a co-pay applies to a particular procedure, the deductible usually does not apply, e.g., physician office visit co-pay - the insured pays the co-pay for the exam and the health insurance company pays the rest of the charge for the exam. Lab tests and x-rays are separate procedures from an exam and so may be subject to deductible and coinsurance even though the exam is covered by a co-pay.

Dental services: services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Discharge planning: the evaluation of a member's medical needs and arrangement of appropriate care after discharge from a facility.

Durable medical equipment: any equipment that can withstand repeated use, is made to serve a medical condition, is useless to a person who is not ill or injured, and is appropriate for use in the home.

Effective date: the date coverage begins.

Elective surgery: a procedure that does not have to be performed on an emergency basis and can be reasonably delayed. Such surgery may still be considered medically necessary.

Emergency: the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Explanation of benefits: also known as an EOB, a printed form sent by an insurance company to a member after a claim has been filed and adjudicated. The EOB includes such information as the date of service, name of provider, amount covered and patient balance. An explanation of Medicare benefits, or EOMB, is similar, except it is sent following submission of a Medicare claim.

Family membership: a membership that covers two or more persons (the subscriber and one or more dependents).

Formulary: a list of drugs that a health insurance company considers to include the most cost-effective alternatives because there may be two or more drugs used for the same therapeutic effect, at different prices. If a non-formulary drug is prescribed, there is usually a higher copay and/or coinsurance to be paid. Formulary usually applies only to brand name drugs. Formularies vary between health insurance companies.

Grievance: a written complaint about the quality of care, denial of a benefit or service received from a provider.

Group Health Insurance: health insurance purchased by a group not formed for the purpose of buying health insurance. Typically, the purchaser is an employer or an employee union. Small group is usually considered to be 50 employees or less employed (not 50 enrolling) and large group is usually more than 50 employees employed.
An association may also sponsor a group plan. For the plan to be fully insured, a regulated insurance company must be prepared to underwrite the group. If enrollment is dependent on the results of a health history questionnaire, that is not a true group plan, but in substance amounts to nothing more than individual coverage under the guise of an "association" in order to fool the buyer into thinking that this is a unique opportunity at a special low premium price. For comparable benefits, the premium may in fact be higher than honestly presented alternative individual coverage.

Health Insurance: a promise to pay for unexpected medical expenses in return for periodic payment of a premium. The promise is made by an insurance company licensed to do business in the state. Supplementary coverage, e.g., up to the plan deductible, may be provided by self-funding by an employer or union or other such organization. Other types of coverage, e.g., provided by a group of physicians in a pre-paid plan would also be licensed by the state. A pre-paid plan is based on a promise to provide care rather than a promise to pay for expenses incurred.

Health Plan Description Form: a state mandated document which all health insurers must provide to help consumers better understand and compare coverage from different insurers.

Health benefit ID card: the card the insurer gives members with information such as the subscriber's name, number and date issued.

Health Savings Account: a bank account or account at a financial institution that qualifies under federal law for special tax treatment. Contributions to the health savings account are tax deductible without any itemizing being necessary on schedule A of the form 1040 individual tax return. Health insurance coverage meeting Internal Revenue Code guidelines must be held to be eligible to open the health savings account and take the tax deduction. You may find such health insurance referred to as an "HSA-qualified high deductible health plan" or "Health Savings Account plan".

Holistic medicine: various preventive and healing techniques, that are theoretically based on the influence of the external environment and the various ways different body tissues affect each other along with the body's natural healing powers.

Home health agency: An agency certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal "Social Security Act," as amended, for home health agencies. A home health agency is primarily engaged in arranging and providing nursing services, home health aide services, and other therapeutic and related services.

Home health care: the special term for skilled nursing, occupational therapy and other health-related services provided at home by a certified home health agency.

Home health services: the following services provided by a certified home health agency under a plan of care to eligible members in their place of residence: professional nursing services; certified nurse aide services; medical supplies, equipment, and appliances suitable for use in the home; and physical therapy, occupational therapy, speech pathology and audiology services.

Hospice agency: an agency licensed by the Colorado Department of Public Health and Environment to provide hospice care in this state. A hospice is a centrally administered program of palliative, supportive and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient care, home health care and follow up bereavement services available 24 hours a day, seven days a week.

Hospice care: an alternative way of caring for terminally ill individuals that stresses palliative care rather than curative or restorative care. Hospice care focuses on the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the member. Hospice care addresses physical, social, psychological and spiritual needs of the member and the member's family.

Hospital: a health institution offering facilities, beds and continuous services 24 hours a day and meets all licensing and certification requirements of local and state regulatory agencies.
Individual health insurance: a category of licensed and regulated health insurance that includes coverage for dependent family members (spouse, minor children, dependent adult full time students up to a specified age) if included in the same application. The other major category is group coverage issued to employers for employees. There may be other categories such as association coverage recognized in a particular state.

Individual membership: a membership covering one person (the subscriber).

In-network: a term for providers or facilities that enter into a network agreement with the insurer.

Inpatient medical rehabilitation: care that includes a minimum of three hours of therapy, e.g., speech therapy, respiratory therapy, occupational therapy and/or physical therapy, and often some weekend therapy. Inpatient medical rehabilitation is generally provided in a rehabilitation section of a hospital or a freestanding facility. Some skilled nursing facilities have "rehabilitation" beds.

Laboratory and pathology services: testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material that has been removed from the body.

Long-term acute care facility: an institution that provides an array of long-term critical care services to members with serious illnesses or injuries. Long-term acute care is provided for patients with complex medical needs. These include high-risk pulmonary patients with ventilator or tracheotomy needs, medically unstable members, extensive wound care or post operative surgery wound members, and low level closed head injury members. LTAC facilities do not provide care for low intensity patient needs.

Managed care: a system of health care delivery the goal of which is to give members access to quality, cost effective health care while optimizing utilization and cost of services, and measuring provider and coverage performance.

Maximum benefit allowance: the maximum dollar amount determined and approved by the insurer which the insurer allows for covered services and procedures. The insurer's determination of a maximum benefit allowance is the maximum amount the insurer approves for any particular service. Cost sharing amounts are based on this allowance and on the allowance and are the amounts the member pays to a provider.

Medical supplies: items (except prescription drugs) required for the treatment of an illness or injury.

Medicare: a federally funded health insurance program that provides benefits for people age 65 and older. Some individuals under age 65 who are disabled or who have end stage kidney disease also are eligible for Medicare benefits.

Member: the subscriber or any dependent who is enrolled for coverage under the policy.

Benefit year: The member's benefit year begins on the subscriber's effective date, and expires either on the following December 31 for a calendar year basis, or on the day prior to the anniversary of the effective date for a policy year basis; the new benefit year commences on each subsequent January 1 or effective date anniversary respectively.

Mental health condition: non-biologically based mental conditions with a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression).

Out-of-pocket annual maximum: the maximum that you may be liable for during a specified period. Add the deductible plus coinsurance plus possible co-pays/facility charges to get a realistic total reachable out-of pocket amount per benefit year.

Outpatient medical care: non-surgical services provided in a provider's office, the outpatient department of a hospital or other facility, or the member's home.

Physical therapy: the use of physical agents to treat disability resulting from disease or injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage and therapeutic exercise. Physical therapy must be performed by a physician or registered physical therapist.

Physician: A doctor of medicine or osteopathy who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

PPO provider: a participating facility provider or a participating professional provider that has entered into an additional agreement with the insurer, to limit charges for services performed under the coverage.

Preauthorization: a process in which requests for services are reviewed prior to service for approval of benefits, length of stay and appropriate location.

Pharmacy: an establishment licensed to dispense prescription drugs and other medications through a licensed pharmacist upon an authorized health care professional's order.

Preauthorization: the process applied to certain drugs and/or therapeutic categories to define the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the pharmacy and therapeutics committee.

Preferred Provider Organization (PPO): a name invented for claims networks which have pre-agreed prices for procedures and a code for each procedure. The members are physicians, other medical professionals, hospitals, and other medical facilities.

Premium: a periodic, usually monthly, charge that the insured individual and/or group must pay to establish and maintain coverage.

Pre-paid Plan: a promise to provide medical care in return for the periodic payment of a premium. The promise is made by a group of physicians and may include hospitals and other facilities. By contrast, insurance is a promise to indemnify or pay certain expenses incurred, not a promise to provide care.

Preventive care: comprehensive care that emphasizes prevention, early detection and early treatment of conditions through routine physical exams, immunizations and health education.

Private duty nursing services: services that require the training, judgment and technical skills of an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). Such services must be prescribed by the attending physician for the continuous medical treatment of the condition.

Producer: A person licensed by the state to sell insurance for insurance companies. In the vernacular, and in some states, producers are also called "agents" or "brokers", but since there is no practical reason for a distinction, many states now have only one license, that of insurance "Producer".

Qualified, Qualifying: (i) meeting the requirements of the Internal Revenue Code so as to be tax deductible or otherwise tax advantaged. (ii) For a Health Savings Account, qualifying medical expenses are those that may be paid out of the account without any tax penalty. (iii) Health insurance qualifying the insured for a Health Savings Account has certain insurance plan features required by the Internal Revenue Code.

Radiation therapy: X-ray, radon, cobalt, betatron, telocobalt, radioactive isotope treatment and similar treatments for malignant diseases and other medical conditions.

Rateup: an increase in periodic premium which may be charged for various reasons, e.g., certain pre-existing conditions, tobacco use, certain occupations, certain avocations (dangerous hobbies) Reconstructive surgery: surgery that restores or improves bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. Such surgery may have a coincidental cosmetic effect.

Referral: authorization given to a member to visit another provider.

Renewal: usually the annual anniversary of the effective date when changes can be made to the insurance contract, e.g., insurer changes the price, employer changes options in its group plan or changes to another plan.

Room expenses: expenses that include the cost of the room, general nursing services and meal services for the member.

Second Opinion: a visit to another professional provider (following a first visit with a different provider) for review of the first provider's opinion of proposed surgery or treatment.

Second surgical opinion: a mechanism used by managed care organizations to reduce unnecessary surgery by encouraging individuals to seek a second opinion prior to specific elective surgeries. In some cases, the health coverage may require a second opinion prior to a specific elective surgery.

Short Term Health Insurance: health insurance coverage that is of limited duration, usually a six month maximum period. The scope of coverage is usually comprehensive, but when the term of coverage is over, the policy cannot be continued or renewed. However, in most states it can be re-bought for another six month period.

Sub-acute medical care: medical care that requires less care than a hospital but often more care than a skilled nursing facility. Sub-acute medical care can be in the form of "transitional care" when a member's condition is improving, but the member is not ready for a skilled nursing facility or home health care.

Subscriber: (i) the person in whose name the membership with the insurer is established. The subscriber may or may not be insured under the policy. (ii) The person(s) who signed the application.

Surgery: any variety of technical procedures for treatment or diagnosis of anatomical disease or injury, including, but not limited to cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, and other invasive procedures. Covered surgical services also include usual and related anesthesia and pre- and post-operative care, including recasting.

Surgical assistant: an assistant to the primary surgeon for required surgical services provided during a covered surgical procedure. the insurer, at its sole discretion, determines which surgeries do or do not require a surgical assistant.
Ultrasound: a radiology imaging technique that uses high frequency sound waves to see organs or the fetus in a pregnant woman.

Underwriting: the process by which an insurance company or pre-paid plan determines whether to accept or reject an application for coverage or to issue coverage with certain modfications. For health plans, modifications may include excluding coverage for identified medical conditions permanently or for a specified period, or an additional premium charge.

Urgent care: care provided for individuals who require immediate medical attention but whose condition is not life-threatening (non-emergency).

Utilization management: a process of integrating review of medical services and care management in a cooperative effort with other parties, including patients, physicians, and other health care providers and payers.

Well-child visit: a physician visit that includes the following components: an age-appropriate physical exam, history, anticipatory guidance and education (e.g., examining family functioning and dynamics, injury prevention counseling, discussing dietary issues, reviewing age-appropriate behaviours, etc.), and assessment of growth and development. For older children, a well-child visit also includes safety and health education counseling.

X-ray and radiology services: services including the use of radiology, nuclear medicine and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.