

TERMS AND DEFINITIONS

Agent or Broker	An insurance professional licensed to sell health insurance in New Hampshire (referred to as “producer” in NH).
Asset	Those things in your business that have value. For example, a building, inventory, personnel, etc.
Association	A group of businesses, organizations, or individuals who join together for professional purposes such as professional development, advocacy, or group purchasing. An association may, as part of its activities, offer insurance products to its members. Examples of associations include the Chamber of Commerce, American Association of Manufacturers, Retail Merchants Association, Restaurant and Lodging Association, Business and Industry Association, etc.
Beneficiary	The person or entity designated by the owner of an insurance policy, annuity, or retirement account who is to receive the proceeds of the insurance policy, annuity, or retirement account upon the death of the owner. Anyone can be named as a beneficiary (relative, non-relative, pet, corporation, partnership, trustee, or charity).
Carrier	An insurer, managed health plan, or other organization that underwrites or administers a range of health benefit programs.
COBRA	A federal law that provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporarily continue health insurance at group rates. This health insurance is only available when it would be lost due to certain specific events (eg., loss of job, divorce, death).
Continuation Coverage	A New Hampshire law that allows an extension of health insurance to enrolled members who have lost employment, finalized a divorce, or had another qualifying incident that would cause them to lose their health benefits. Health insurance may continue for 18

to 36 months depending on the reason for the loss of health insurance.

Co-insurance	The amount you are responsible for before the carrier pays. Most commonly used for hospitalization. For example, you must pay 20% of the hospital bill and the carrier will pay the other 80%. There is often a maximum amount that would be your responsibility. For example, 20% up to a maximum of \$ 2,000.
Co-payment	The part of medical expenses that you must pay. For example, \$20 per office visit; \$15 per prescription.
Coverage	Protection under an insurance policy.
Covered Services	Those benefits and services listed in the subscriber agreement that are paid for by the carrier.
Deductible	The amount you must pay for medical expenses before the carrier pays. For example, \$1,000 per hospitalization.
Dependent	Members of the family who are eligible to enroll in the health insurance.
Discount Card/Program	Health care services are offered at a reduced rate for the person participating in the program. For example, glasses may be 20% less for the person holding a discount card. Note: a discount card/program is not insurance.
Eligible Employee	A person or persons designated in the group contract as being eligible to enroll in the insurance plan. For example, only those employees who work 40 hours per week; new employees who have worked for 3 months, etc.
Eligibility	Criteria that you must meet to use a publicly-funded program, usually tied to age, disability, and household income.
Exclusions	Those services that the carrier will not pay for, as outlined in the insurance contract or subscriber agreement. For example, cosmetic services; experimental, investigational or unproven services; custodial care, etc.

Formulary	A list of approved prescription drugs and related supplies (for example, diabetic supplies, needles, syringes) chosen by a carrier for use in treating patients. Drugs not included in the formulary are not paid for unless a physician specifically prescribes it or unless you are willing to pay an added charge.
Formulary, Generic	Drug products, not protected by a trademark, that have the same active chemical ingredients as those sold under proprietary brand names. Usually these are the least costly when compared to name brand drugs.
Formulary, Name Brand	A prescription drug protected by a trademark that is on the formulary. The name brand usually costs more than its generic equivalent. Not all name brand prescription drugs have a generic equivalent.
Grace Period	The time period after the premium is due, during which the premium can be paid with no interest charged and the health insurance remains in effect.
Group Health Insurance	Health insurance that is offered to a combination of individuals rather than to an individual person. For example, to a business for its employees.
Guaranteed Issue	The insurance carrier must offer you health insurance.
Guaranteed Renewal	If you have an existing policy, the carrier must renew that policy.
Health Insurance Policy	The policy (contract) that pays for health services when the person insured is ill or injured.
Health Maintenance Organization (HMO)	An organization that provides and manages health services for members in return for a fixed, paid premium. The person with an HMO will choose a primary care physician (PCP) from an approved provider list. The PCP will be responsible for routine care and referral to specialists.
Health Savings Accounts (HSAs)	Special savings accounts you can open to pay for medical expenses. To participate, you must have a health insurance policy with a high deductible (for example, \$5,000).

HSA accounts can be used for co-payments, deductibles, and certain medical expenses not covered by the high deductible health plan. Note: HSAs are not insurance.

Health Statement

A medical statement that provides health information about the employee and family members. It includes questions about health conditions (cancer, heart attack, stroke, etc.), treatment for conditions (alcohol or drug abuse, diabetes, mental health conditions, high blood pressure), HIV/AIDS, tobacco use, physician information, medications. This information may be used to set insurance premiums or to determine eligibility for other insurance programs; the [New Hampshire Health Plan](#), for example.

**High Deductible
example, \$ 5,000)
Policy**

A health insurance policy with a high deductible (for meant to cover a high cost incident (such as hospitalization) over a long period of time. Usually used in conjunction with a health savings account (HSA).

HIPAA

A federal law that provides rights and protections for employees and beneficiaries with group health insurance. HIPAA offers protections for both health insurance offered through an employer and for individual health insurance policies sold by insurance carriers.

Indemnity

(Fee-for-Service)

Health insurance, often referred to as fee-for-service, that reimburses actual expenses of covered services. Usually, you must pay a deductible before the co-insurance is paid by the carrier. In addition to the deductible, you must also pay your co-insurance amount. For example, with a \$1,000 deductible plan you must pay the first \$1,000. Once the deductible is paid, the carrier will pay 80% and you will pay 20%, up to the amount specified in the insurance policy (for example up to \$2,000). After that, the carrier pays 100% of the additional cost. This option allows you the most flexibility in terms of choosing the providers you want to use. It may include discounts for using a particular network of providers.

Individual Health Insurance	Health insurance purchased for a single person.
In-network Providers	Providers who are part of the carriers' contracted network of providers. When you use these providers, there is less cost to you. Also called "participating providers."
Insurance	The business of insuring property, life, health, etc. against loss or harm occurring as a result of a specified event such as death, disability, fire, etc. in consideration for a payment (premium) that is tied to the risk involved.
Insured Person	The person in whose name the insurance policy is issued. For example, the eligible employee or the self-employed individual.
Late Enrollee	A person applying for health insurance outside of the open enrollment period.
License	The legal authority that allows brokers, agents, and carriers to do business in the state. Each state has its own licensing requirements and procedures. To find out if an agent, broker, or carrier is licensed in New Hampshire, visit the NH Department of Insurance website .
Life Insurance	Protection against the death of an individual in the form of a payment to the beneficiary – usually a family member, business, or institution.
Limited Benefit Plans	A type of health insurance that provides coverage in a particular health setting, certain conditions or certain diseases. Examples of this type of coverage are basic hospital, basic medical-surgical, hospital confinement, accidents only, specific diseases such as cancer, and other limited items such as dental or vision.
Long-term Care Insurance	A type of insurance designed to cover the costs associated with long-term care in a nursing home and/or home health services provided in lieu of entering a nursing home. This type of insurance pays for services not covered by Medicaid or Medicare.

Long-term Disability Insurance	A type of insurance designed to provide monthly income payments to the insured person who has a long-term disability, as defined by the policy. Payments continue for as long as the insured remains disabled.
Mandated Coverage	Benefits or services required by the state or federal government. For example, mental health services.
Managed Care	A plan where you pay a reduced fee to see a primary care physician. All care from specialists or other providers must be pre-approved by the primary care physician. Managed care includes HMO, PPO, and POS plans.
Maximum Out-of-Pocket	A stated limit on the out-of-pocket expenses you must pay. Once the limit is reached, all expenses will be paid by the carrier. For example, \$2,000 per individual, \$5,000 per family.
Medicaid	A medical program provided by the federal government and administered by the state. It provides benefits, according to the state plan, for the low income, blind and disabled, and dependent children. For information about the plan in New Hampshire visit NH Department of Health & Human Services .
Medicare	A national program of health insurance that provides benefits primarily to persons over the age of 65 and others eligible for Social Security benefits. For additional information visit Medicare .
Medigap	Private health insurance purchased to help pay for Medicare costs not covered by Medicare. Also called "Medicare Supplemental Coverage." These plans are offered by a variety of carriers.
NH Health Plan	The state high risk pool that provides health insurance to NH residents who can't get health insurance from carriers, have a pre-qualifying condition, or are otherwise eligible for the high risk pool. For more information visit NH Health Plan .

NH Healthy Kids	A New Hampshire program that provides health coverage for eligible children up to age 19. Go to www.nhhealthykids.com for additional information.
Non-formulary Drugs	Prescription drugs not included on the carriers' formulary. These drugs are the most expensive since the carrier does not cover as much (or any) of the cost.
Non-participating Provider	Providers who are not part of the preferred contract network of the carrier. To use these providers you must have a referral from a primary care physician. It may cost you more than using in-network providers. Also called "out-of-network provider." If you do not have a referral from your primary care physician and use an out-of-network provider, you will be responsible for paying the entire cost of the visit and treatment.
Open Enrollment	The time period established by the carrier, no less frequently than once in any twelve consecutive months, during which eligible persons may enroll in the health plan. <u>For small employers, group of 1 (self-employed), open enrollment is only during March and September.</u> Carriers can offer health insurance at other times if they choose to do so or the self-employed individual can request a special open enrollment period from the carrier.
Out-of-network Providers	Providers who are not part of the preferred contract network of the carrier. To use these providers, you must have a referral from a primary care physician. It may cost you more than using in-network providers. Also called "non-participating provider." If you do not have a referral from your primary care physician and use an out-of-network provider, you will be responsible for paying the entire cost of the visit and treatment.
Out-of-pocket Expenses	Any medical costs that you must pay. For example, the total cost of a physician office visit, the total cost of a prescription, co-payments and deductibles.
Participating Pharmacy	A retail or mail order pharmacy that has a contract with the carrier.

Participating Provider	Providers who are part of the carriers' contracted network of providers. When you use these providers, you pay less. Also called "in-network provider."
Point of Service (POS)	A health plan that allows you to pay lower co-payments for in-network providers who participate in the plan. You may use out-of-network providers without a referral, but you will pay more.
Pre-existing Conditions	Any single or multiple physical and/or mental impairment or disease that exists before the insurance begins. Many plans stipulate a time period after which you can begin to receive care for pre-existing conditions.
Preferred Provider Organization (PPO)	A network of providers who contract with an indemnity plan to provide services. It usually costs less if you use providers in the approved network. It usually costs more if you use providers outside of the approved network.
Premium	The amount paid for health insurance, usually paid in monthly installments.
Primary Care Provider (PCP)	A physician under contract with a health plan who you designate as your primary physician. The physician is usually in family practice, internal medicine, pediatrics, or general practice. The PCP provides your care and makes referrals to specialists when necessary.
Producer	An insurance agent or broker who sells and services health insurance.
Provider	A generic term used to describe a physician, pharmacist, dentist, hospital, group practice, nursing home, or any individual or group of individuals who provides health care services.
Qualifying Events	Specific events that allow the continuation of group health insurance under COBRA. These events are: For employees:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct
- Reduction in the number of hours of employment

For spouses:

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered employee becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

For dependent children:

- Loss of dependent child status under plan rules
- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered employee becoming entitled to Medicare
- Divorce or legal separation of the covered employee (parent) that impacts the child's health insurance status
- Death of the covered employee

Rating Factors

Items that are used in calculating the premium that will be charged. For example, age, industry, geography, health condition.

Referral

The written authorization from the primary care physician (PCP) for medically necessary services from a specialist or non-participating provider.

Rider

An addition to the health insurance policy that modifies it to include or exclude certain coverage. For example, a rider that pays for maternity costs or that won't pay for a pre-existing condition.

<p>Self-Employed Individual</p>	<p>An individual that is in business, without other employees. In New Hampshire, a self-employed person is considered a group of 1 for health insurance. This allows the self-employed person to purchase small employer (group) insurance as well as individual insurance. <u>For small employers, group of 1 (self-employed), open enrollment is only during March and September.</u> Carrier can offer health insurance at other times if they choose to do so or the self-employed individual can request a special open enrollment period from the carrier.</p>
<p>Short-term Disability Insurance</p>	<p>Health insurance that provides income payments, for a specific amount of time, to the insured wage earner whose income is interrupted or terminated because of illness or accident.</p>
<p>Small Employer</p>	<p>A business or organization which employed one to 50 employees on average (including owners and self-employed persons) on business days during the previous calendar year.</p>
<p>Small Employer Health Insurance</p>	<p>A group health insurance product for employers with 1 to 50 employees. Under New Hampshire RSA 420-G, the self-employed person is a group of 1 and may purchase group health insurance.</p>
<p>Special Enrollment Periods</p>	<p>Self-employed individuals (group of 1) have two open enrollment periods during the months of March and September of each calendar year. Carriers can offer health insurance at other times if they choose to do so. If self-employed individuals seek health insurance during other times of the year, they will be treated as late enrollees unless all of the following are true:</p> <ol style="list-style-type: none"> 1. The self-employed individual was covered under public or private health coverage on the last day of the most recent open enrollment period;

2. The self-employed individual has lost this coverage due to the coverage being terminated; and
3. The self-employed individual requests enrollment in another group plan within 30 days of the termination of this coverage.

A request for a special enrollment period should be made to the carrier. Your agent or broker can be your advocate for this request.

Specialist

Any physician or other provider for whom a referral from the primary care physician is required. For example, cardiologist, dermatologist, etc.

Subscriber Agreement

The formal document from the carrier that describes the covered health services, exclusions, referral process, appeal process, out-of-area care, etc.

Waiting Period

A period of time, determined by the employer, which must expire before an employee is eligible for health insurance.

Sources:

NH State Statutes relative to health insurance, particularly, RSA 420-G.

Rognehaugh, R. *The Managed Health Care Dictionary*, Gaithersburg, MD: Aspen Publishers, Inc., 1996.

Rubin, H.W. *Dictionary of Insurance Terms* 2nd Edition, New York: Barron's Educational Series, Inc., 1991.