Advanced Gastroenterology
Advanced Endoscopy Center
Innovative, personalized care for your digestive health

Glossary of Insurance Terms

- Allowable- Amount that a health plan will pay for a certain service. May be less than what a medical provider typically charges.
- Appeal- Request made to an insurance company to reconsider a decision, such as denying a claim or refusing to cover a drug of service.
- Benefit Cap- Total dollar amount that a health plan will pay for covered healthcare services during a specified period, such as one year.
- Case Management- A process by which the patient and a case manager work with the patient's doctor to design a plan to help the patient to achieve treatment goals in the most cost-effective manner.
- Coordination of Benefits- When a patient is covered under more than one health insurance policy, this requires that all of the plans work together to pay the benefits and eliminate duplication of services.
- Co-Payment- A predetermined fee that a plan member pays for healthcare services.
- Co-Insurance- Amount a beneficiary is required to pay for services after a deductible has been paid; usually a percentage of the amount an insurer will reimburse a medical provider for certain services.
- Deductible- Amount an individual must pay for medical expenses before insurance covers a portion of the costs.
- Effective Date- The date that coverage began for a person enrolled in a health plan.
- Explanation of Benefits (EOB)- A health plan's summary (written or electronic) of a bill for medical services and details of how the claim was processed for payment.
- In-Network- Refers to a provider of medical services that agrees to a health plan network's terms and conditions. Members may save on costs if they seek care through an in-network physician or facility.
- Lifetime Maximum Benefit- The maximum dollar amount that a health plan will pay for all healthcare services for an insured individual.
- Medical Necessity- Clinical information provided by a medical professional to a health plan to justify the appropriateness of medical services provided for the diagnosis or treatment of a condition of illness.

- Medicare Advantage- A plan for Medicare beneficiaries that is different from traditional Medicare and is offered through commercial insurers that contract with Medicare to provide enrollees with all Medicare Part A and Part B benefits. Some Medicare Advantage plans also offer Medicare Part D prescription drug benefits (these are known as Medicare Advantage Prescription Drug plans or MA-PDP's).
- Network- A group of doctors, hospitals, and/or other healthcare providers contracted to provide services to insured individuals.
- Out-of-Network- A medical provider or healthcare facility that is not part of a health plan's list of preferred healthcare providers.
- Out –of-Pocket Maximum- The total dollar amount (often based on a percentage of costs) that a health plan will require an insured individual to pay for healthcare services during a fixed time period, such as one year. May or may not include deductible.
- Participating Provider- A medical professional or organization that has contracted with a health plan to render medical services or supplies to insured persons. Providers include hospitals, physicians, and other medical facilities that are part of a health plan's network. Providers include hospitals, physicians, and other medical facilities that are part of a health plan's network.
- Pre-Existing Condition- An illness, injury or condition for which the insured individual received medical advice, treatment, services, or supplies; had diagnostic tests done or recommended; had medicines prescribed or recommended; or had symptoms typically within a certain number of months (time periods may vary depending on plan and state law) prior to the start date for the insurance policy.
- Prior Authorization- This refers to a decision made by the payer to cover or to deny coverage for charges before the services are provided.
- Referral- When a primary care doctor transfers care of a patient to a specialist.