Certified Professional in Healthcare Virtual Assistants

# Health Insurance

Aca healthcare refers to the healthcare system implemented in the United States, also known as the Affordable Care Act, which aims to increase health insurance quality and affordability, lower the uninsured rate by expanding insurance coverage, and reduce the costs of healthcare for individuals and the government. Addiction therapy is a type of treatment that helps individuals overcome their addiction to substances such as drugs or alcohol, and is often covered under health insurance plans. Adjudication process in health insurance refers to the process by which an insurance company determines whether a claim is valid and should be paid, and the amount that should be paid. Administrative services are tasks performed by healthcare providers and insurance companies to manage and process health insurance claims, such as billing and paperwork. Admission criteria for hospitals and healthcare facilities refer to the standards and requirements that patients must meet in order to be admitted for treatment, and may include factors such as medical necessity and insurance coverage. Advance directives are documents that outline a patient's wishes for medical treatment in the event that they become unable to communicate, and may include living wills and durable powers of attorney. Adverse selection in health insurance occurs when individuals who are more likely to need medical care are more likely to purchase health insurance, which can drive up costs for the insurance company. Affordable care refers to healthcare that is affordable and accessible to individuals and families, and may be subsidized by the government or provided through employer-sponsored health insurance plans. Age limits in health insurance refer to the maximum age at which an individual can purchase or renew a health insurance policy, and may vary depending on the type of policy and the insurance company. Ambulatory care refers to medical care that is provided on an outpatient basis, such as in a doctor's office or clinic, and may include services such as routine check-ups and diagnostic testing. Ancillary services in healthcare refer to services that are provided in addition to primary medical care, such as physical therapy, occupational therapy, and speech therapy. Annual limits in health insurance refer to the maximum amount of money that an insurance company will pay for medical expenses in a given year, and may vary depending on the type of policy and the insurance company. Appeal process in health insurance refers to the process by which a patient or healthcare provider can dispute a decision made by an insurance company, such as a denial of coverage or a claim payment. Assignment of benefits in health insurance refers to the process by which a healthcare provider assigns payment for medical services to the patient's insurance company, rather than billing the patient directly. Attributable risk in health insurance refers to the risk of a particular health outcome or event that can be attributed to a specific factor, such as a genetic predisposition or environmental exposure. Authorization form in health insurance is a document that patients must sign in order to authorize their healthcare provider to release medical information to their insurance company. Average cost in health insurance refers to the average amount of money that an insurance company pays for medical expenses, and may be used to determine

premiums and coverage levels. Benefit package in health insurance refers to the set of medical services and treatments that are covered under a particular health insurance policy, and may include services such as doctor visits, hospital stays, and prescription medications. Benefit period in health insurance refers to the period of time during which an insurance company will pay for medical expenses, and may vary depending on the type of policy and the insurance company. Beneficiary designation in health insurance refers to the process by which a patient designates a beneficiary to receive benefits in the event of their death, and may include life insurance policies and retirement accounts. Broker fee in health insurance refers to the fee paid to an insurance broker for their services in helping patients purchase and manage their health insurance policies. Budget neutral in health insurance refers to a policy or program that is designed to have no net effect on the budget of an insurance company or government program, and may include cost-saving measures such as reducing administrative costs. Capitation payment in health insurance refers to a payment arrangement in which a healthcare provider is paid a fixed amount per patient for a specified period of time, regardless of the actual cost of care. Care coordination in health insurance refers to the process by which healthcare providers and insurance companies work together to coordinate patient care and ensure that patients receive necessary medical services. Case management in health insurance refers to the process by which healthcare providers and insurance companies work together to manage patient care and ensure that patients receive necessary medical services, and may include services such as disease management and utilization review. Catastrophic coverage in health insurance refers to a type of health insurance policy that provides limited coverage at a lower cost, and is often designed for individuals who are unable to afford more comprehensive coverage. Certification program in health insurance refers to a program that certifies healthcare providers as meeting certain standards of quality and competency, and may include programs such as the Certified Professional in Healthcare Virtual Assistants. Claim form in health insurance is a document that healthcare providers use to submit claims for payment to insurance companies, and may include information such as patient demographics and medical services provided. Claim processing in health insurance refers to the process by which insurance companies review and pay claims submitted by healthcare providers, and may include services such as adjudication and payment. Clinical trials in health insurance refer to research studies that are designed to evaluate the safety and effectiveness of new medical treatments and technologies, and may be covered under health insurance policies. Co-insurance rate in health insurance refers to the percentage of medical expenses that a patient is responsible for paying after meeting their deductible, and may vary depending on the type of policy and the insurance company. Co-pay ment in health insurance refers to a fixed amount that a patient pays for medical services, such as doctor visits or prescription medications, and may vary depending on the type of policy and the insurance company. Community risk in health insurance refers to the risk of a particular health outcome or event that can be attributed to a specific community or population, and may include factors such as environmental exposures and socioeconomic status. Comprehensive coverage in health insurance refers to a type of health insurance policy that provides broad coverage for a wide range of medical services, and may include services such as doctor visits, hospital stays, and prescription medications. Concurrent review in health insurance refers to the process by which insurance companies review medical services and treatments while

a patient is still receiving care, and may include services such as utilization review and case management. Condition exclusion in health insurance refers to a provision in a health insurance policy that excludes coverage for certain medical conditions or services, and may vary depending on the type of policy and the insurance company. Consolidated omnibus in health insurance refers to a budget reconciliation act that makes changes to healthcare programs and policies, and may include provisions such as changes to Medicare and Medicaid. Consumer driven in health insurance refers to a type of health insurance policy that allows patients to take a more active role in managing their healthcare costs and services, and may include services such as health savings accounts and flexible spending accounts. Continuation coverage in health insurance refers to the continuation of health insurance coverage after a patient has left their job or experienced a change in employment status, and may include provisions such as COBRA. Contract provider in health insurance refers to a healthcare provider who has a contract with an insurance company to provide medical services to patients, and may include services such as doctor visits and hospital stays. Conversion option in health insurance refers to the option to convert a group health insurance policy to an individual policy, and may be available to patients who have experienced a change in employment status or other qualifying event. Coordination of benefits in health insurance refers to the process by which insurance companies coordinate payment for medical expenses when a patient has multiple health insurance policies, and may include services such as coordination of benefits and subrogation. Copayment waiver in health insurance refers to a provision in a health insurance policy that waives the copayment for certain medical services or treatments, and may vary depending on the type of policy and the insurance company. Cost sharing in health insurance refers to the provision in a health insurance policy that requires patients to pay a portion of their medical expenses, and may include services such as deductibles, co-insurance, and copayments. Cost containment in health insurance refers to the strategies and techniques used by insurance companies to reduce healthcare costs, and may include services such as utilization review and case management. Credentialing process in health insurance refers to the process by which healthcare providers are evaluated and certified as meeting certain standards of quality and competency, and may include services such as licensure and accreditation. Creditable coverage in health insurance refers to health insurance coverage that is considered creditable for purposes of determining pre-existing condition exclusions, and may include services such as group health insurance and individual health insurance. Current procedural in health insurance refers to a coding system used to describe medical procedures and services, and may include services such as surgical procedures and diagnostic testing. Data analysis in health insurance refers to the process by which insurance companies analyze data on patient outcomes, medical services, and healthcare costs, and may include services such as risk adjustment and predictive modeling. Deductible amount in health insurance refers to the amount of money that a patient must pay out-of-pocket for medical expenses before their insurance coverage kicks in, and may vary depending on the type of policy and the insurance company. Defined benefit in health insurance refers to a type of health insurance policy that provides a fixed amount of money for medical expenses, and may include services such as fixed indemnity insurance. Dental insurance in health insurance refers to a type of health insurance policy that provides coverage for dental services, and may include services such as routine cleanings and

fillings. Dependent coverage in health insurance refers to the coverage provided to dependents of the primary policyholder, and may include services such as coverage for spouses and children. Disability income in health insurance refers to a type of insurance that provides income replacement for individuals who are unable to work due to illness or injury, and may include services such as short-term and long-term disability insurance. Disenrollment period in health insurance refers to the period of time during which patients can disenroll from a health insurance policy, and may include services such as open enrollment and special enrollment periods. Disease management in health insurance refers to the process by which healthcare providers and insurance companies work together to manage patient care and improve health outcomes for patients with chronic diseases, and may include services such as case management and coordination of care. Donut hole in health insurance refers to a gap in coverage that occurs when patients have exceeded their initial coverage limit but have not yet reached their catastrophic coverage limit, and may include services such as Medicare Part D. Dual eligible in health insurance refers to individuals who are eligible for both Medicare and Medicaid, and may include services such as dual eligible special needs plans. E-health record in health insurance refers to an electronic record of a patient's medical history and health information, and may include services such as electronic health records and personal health records. Electronic claims in health insurance refers to the process by which healthcare providers submit claims electronically to insurance companies, and may include services such as electronic data interchange and claims processing. Emergency services in health insurance refers to medical services that are provided in emergency situations, such as emergency room visits and ambulance services, and may include services such as urgent care and emergency medical technicians. Employer group in health insurance refers to a group health insurance plan that is sponsored by an employer, and may include services such as group health insurance and self-insured plans. Enrollment period in health insurance refers to the period of time during which patients can enroll in a health insurance policy, and may include services such as open enrollment and special enrollment periods. Epidemiology study in health insurance refers to the study of the distribution and determinants of health-related events, diseases, or health-related characteristics among populations, and may include services such as risk assessment and predictive modeling. Evidence based in health insurance refers to the use of scientific evidence to guide medical decision-making and healthcare policy, and may include services such as evidence-based medicine and comparative effectiveness research. Exclusion  rider in health insurance refers to a provision in a health insurance policy that excludes coverage for certain medical conditions or services, and may vary depending on the type of policy and the insurance company. Exclusive provider in health insurance refers to a healthcare provider who has an exclusive contract with an insurance company to provide medical services to patients, and may include services such as exclusive provider organizations and preferred provider organizations. Experimental investigational in health insurance refers to medical services or treatments that are still being tested and have not yet been proven to be safe and effective, and may include services such as clinical trials and off-label use. Explanation of benefits in health insurance refers to a document that explains the benefits and services covered under a health insurance policy, and may include services such as summary of benefits and coverage and explanation of benefits. Extension of benefits in health insurance refers to the extension of health insurance

coverage beyond the initial coverage period, and may include services such as continuation coverage and conversion coverage. Facility fee in health insurance refers to a fee paid to a healthcare facility for medical services, and may include services such as hospital fees and clinic fees. Fee for service in health insurance refers to a payment arrangement in which healthcare providers are paid for each medical service they provide, and may include services such as doctor visits and surgical procedures. Flexible spending in health insurance refers to a type of savings account that allows patients to set aside pre-tax dollars for medical expenses, and may include services such as flexible spending accounts and health savings accounts. Formulary list in health insurance refers to a list of prescription medications that are covered under a health insurance policy, and may include services such as pharmacy benefit management and medication therapy management. Freedom of choice in health insurance refers to the ability of patients to choose their own healthcare providers and medical services, and may include services such as point of service plans and preferred provider organizations. Gatekeeper provider in health insurance refers to a healthcare provider who acts as a primary care provider and coordinates patient care, and may include services such as gatekeeper models and primary care case management. Group health in health insurance refers to a type of health insurance policy that is sponsored by an employer or other organization, and may include services such as group health insurance and self-insured plans. Guaranteed issue in health insurance refers to a provision in a health insurance policy that guarantees coverage for certain medical conditions or services, and may vary depending on the type of policy and the insurance company. Guaranteed renewal in health insurance refers to a provision in a health insurance policy that guarantees the ability to renew coverage, and may vary depending on the type of policy and the insurance company. Health reimbursement in health insurance refers to a type of arrangement in which an employer reimburses employees for medical expenses, and may include services such as health reimbursement arrangements and flexible spending accounts. Health savings in health insurance refers to a type of savings account that allows patients to set aside pre-tax dollars for medical expenses, and may include services such as health savings accounts and flexible spending accounts. High deductible in health insurance refers to a type of health insurance policy that has a higher deductible than traditional health insurance policies, and may include services such as high deductible health plans and health savings accounts. HMO plan in health insurance refers to a type of health insurance policy that provides coverage for medical services through a network of healthcare providers, and may include services such as health maintenance organizations and preferred provider organizations. Hospital indemnity in health insurance refers to a type of insurance that provides a fixed amount of money for hospital stays, and may include services such as hospital indemnity insurance and fixed indemnity insurance. Incurred claim in health insurance refers to a claim that has been submitted to an insurance company for payment, and may include services such as claims processing and payment. In-network provider in health insurance refers to a healthcare provider who has a contract with an insurance company to provide medical services to patients, and may include services such as preferred provider organizations and health maintenance organizations. Inpatient care in health insurance refers to medical care that is provided in a hospital or other inpatient setting, and may include services such as hospital stays and surgical procedures. Insurable interest in health insurance refers to the financial interest that an

individual has in a particular health insurance policy, and may include services such as insurable interest and ownership interest. Insurance exchange in health insurance refers to a marketplace where patients can purchase health insurance policies, and may include services such as health insurance marketplaces and state-based exchanges. Integrative medicine in health insurance refers to a type of medical care that combines conventional Western medicine with alternative therapies, and may include services such as integrative medicine and complementary medicine. Intensity modulated in health insurance refers to a type of radiation therapy that uses advanced technology to deliver precise doses of radiation to cancer cells, and may include services such as intensity modulated radiation therapy and stereotactic body radiation therapy. Intermediate care in health insurance refers to medical care that is provided in a skilled nursing facility or other intermediate care setting, and may include services such as skilled nursing care and rehabilitation therapy. Internal appeals in health insurance refers to the process by which a patient or healthcare provider can appeal a decision made by an insurance company, and may include services such as internal appeals and external appeals. Lifetime limit in health insurance refers to the maximum amount of money that an insurance company will pay for medical expenses over the course of a patient's lifetime, and may vary depending on the type of policy and the insurance company. Limited network in health insurance refers to a type of health insurance policy that provides coverage for medical services through a limited network of healthcare providers, and may include services such as limited network plans and exclusive provider organizations. Long term in health insurance refers to a type of health insurance policy that provides coverage for an extended period of time, and may include services such as long-term care insurance and disability insurance. Loss ratio in health insurance refers to the ratio of claims paid to premiums collected, and may be used to determine the financial performance of an insurance company. Major medical in health insurance refers to a type of health insurance policy that provides comprehensive coverage for medical expenses, and may include services such as major medical insurance and comprehensive major medical insurance. Mandated benefit in health insurance refers to a benefit that is required by law to be included in a health insurance policy, and may include services such as mandated benefits and essential health benefits. Maximum out of pocket in health insurance refers to the maximum amount of money that a patient is responsible for paying for medical expenses in a given year, and may vary depending on the type of policy and the insurance company. Medicaid program in health insurance refers to a government program that provides health insurance coverage to low-income individuals and families, and may include services such as Medicaid and the Children's Health Insurance Program. Medical necessity in health insurance refers to the determination that a particular medical service or treatment is necessary and appropriate for a patient's condition, and may include services such as medical necessity and utilization review. Medical records in health insurance refers to the documentation of a patient's medical history and health information, and may include services such as medical records and electronic health records. Medicare program in health insurance refers to a government program that provides health insurance coverage to individuals who are 65 or older, and may include services such as Medicare and Medigap. Medicare advantage in health insurance refers to a type of Medicare plan that provides coverage for medical expenses through a private insurance company, and may include services such as Medicare Advantage and Medicare Part C. Medigap

policy in health insurance refers to a type of insurance policy that provides supplemental coverage for medical expenses not covered by Medicare, and may include services such as Medigap and Medicare supplement insurance. Mental health in health insurance refers to the provision of coverage for mental health services, and may include services such as mental health insurance and behavioral health insurance. Minimum essential in health insurance refers to the minimum level of coverage that is required by law for a health insurance policy, and may include services such as minimum essential coverage and essential health benefits. Minimum premium in health insurance refers to the minimum amount of money that a patient must pay for a health insurance policy, and may vary depending on the type of policy and the insurance company. Network provider in health insurance refers to a healthcare provider who has a contract with an insurance company to provide medical services to patients, and may include services such as preferred provider organizations and health maintenance organizations. Non formulary in health insurance refers to a prescription medication that is not included on a health insurance plan's formulary list, and may include services such as non-formulary medications and prior authorization. Non participating in health insurance refers to a healthcare provider who does not have a contract with an insurance company to provide medical services to patients, and may include services such as non-participating providers and out-of-network providers. Out of network in health insurance refers to medical services that are provided by a healthcare provider who does not have a contract with an insurance company, and may include services such as out-of-network providers and non-participating providers. Out of pocket in health insurance refers to the amount of money that a patient is responsible for paying for medical expenses, and may include services such as out-of-pocket costs and cost-sharing. Outpatient care in health insurance refers to medical care that is provided on an outpatient basis, such as in a doctor's office or clinic, and may include services such as outpatient services and ambulatory care. Over the counter in health insurance refers to medications that can be purchased without a prescription, and may include services such as over-the-counter medications and self-care products. Patient protection in health insurance refers to the laws and regulations that are designed to protect patients' rights and interests, and may include services such as patient protection and advocacy. Pay for performance in health insurance refers to a payment arrangement in which healthcare providers are paid based on their performance and quality of care, and may include services such as pay-for-performance and value-based payment. Peer review in health insurance refers to the process by which healthcare providers evaluate the quality and appropriateness of medical services provided by their peers, and may include services such as peer review and utilization review. Pharmaceutical services in health insurance refers to the provision of coverage for prescription medications, and may include services such as pharmacy benefit management and medication therapy management. Point of service in health insurance refers to a type of health insurance policy that allows patients to choose their own healthcare providers and medical services, and may include services such as point of service plans and preferred provider organizations. Policy year in health insurance refers to the period of time during which a health insurance policy is in effect, and may include services such as policy year and plan year. Pre authorization in health insurance refers to the process by which a healthcare provider must obtain approval from an insurance company before providing certain medical services or treatments, and may include services such as pre-

authorization and prior authorization. Pre existing in health insurance refers to a medical condition that existed before a patient purchased a health insurance policy, and may include services such as pre-existing conditions and guaranteed issue. Preferred provider in health insurance refers to a healthcare provider who has a contract with an insurance company to provide medical services to patients, and may include services such as preferred provider organizations and health maintenance organizations. Premium tax in health insurance refers to the tax that is paid on health insurance premiums, and may include services such as premium tax and health insurance tax. Prenatal care in health insurance refers to medical care that is provided to pregnant women, and may include services such as prenatal care and maternity care. Preventive care in health insurance refers to medical care that is provided to prevent illnesses and injuries, and may include services such as preventive care and wellness programs. Primary care in health insurance refers to medical care that is provided by a primary care physician, and may include services such as primary care and routine check-ups. Prior authorization in health insurance refers to the process by which a healthcare provider must obtain approval from an insurance company before providing certain medical services or treatments, and may include services such as prior authorization and pre-authorization. Private fee for service in health insurance refers to a payment arrangement in which healthcare providers are paid for each medical service they provide, and may include services such as private fee-for-service and payment for performance. Prosthetic device in health insurance refers to a device that is used to replace a missing or damaged body part, and may include services such as prosthetic devices and durable medical equipment. Provider network in health insurance refers to a group of healthcare providers who have a contract with an insurance company to provide medical services to patients, and may include services such as provider networks and preferred provider organizations. Psychotherapy session in health insurance refers to a session of psychotherapy or counseling, and may include services such as psychotherapy and behavioral health services. Quality improvement in health insurance refers to the process by which healthcare providers and insurance companies work to improve the quality of care and services provided to patients, and may include services such as quality improvement and performance measurement. Rebate program in health insurance refers to a program that provides rebates or discounts to patients for certain medical services or treatments, and may include services such as rebate programs and discount programs. Reimbursement method in health insurance refers to the method by which healthcare providers are paid for medical services, and may include services such as reimbursement methods and payment arrangements. Reinsurance program in health insurance refers to a program that provides insurance coverage to insurance companies, and may include services such as reinsurance programs and stop-loss insurance. Renewal date in health insurance refers to the date on which a health insurance policy is renewed, and may include services such as renewal date and policy anniversary date. Replacement coverage in health insurance refers to coverage that is provided to replace a previous health insurance policy, and may include services such as replacement coverage and conversion coverage. Rider benefit in health insurance refers to an additional benefit that is added to a health insurance policy, and may include services such as rider benefits and policy endorsements. Risk adjustment in health insurance refers to the process by which insurance companies adjust their premiums and coverage levels to reflect the level of risk associated with a particular patient or

group of patients, and may include services such as risk adjustment and predictive modeling. Routine care in health insurance refers to medical care that is provided on a routine basis, such as check-ups and preventive care, and may include services such as routine care and wellness programs. Self insured in health insurance refers to a type of health insurance plan that is sponsored by an employer or other organization, but is not insured by an insurance company, and may include services such as self-insured plans and administrative services only. Short term in health insurance refers to a type of health insurance policy that provides coverage for a limited period of time, and may include services such as short-term health insurance and temporary health insurance. Skilled nursing in health insurance refers to medical care that is provided in a skilled nursing facility, and may include services such as skilled nursing care and rehabilitation therapy. Small group in health insurance refers to a type of health insurance plan that is sponsored by a small employer or other organization, and may include services such as small group health insurance and small business health insurance. Social security in health insurance refers to the government program that provides financial assistance to individuals who are disabled or retired, and may include services such as social security and Medicare. Special enrollment in health insurance refers to a period of time during which patients can enroll in a health insurance policy outside of the regular open enrollment period, and may include services such as special enrollment periods and qualifying events. Specialist care in health insurance refers to medical care that is provided by a specialist physician, and may include services such as specialist care and referral services. Standard plan in health insurance refers to a type of health insurance plan that provides a standardized set of benefits and services, and may include services such as standard plans and essential health benefits. State health in health insurance refers to the government program that provides health insurance coverage to low-income individuals and families, and may include services such as state health insurance and Medicaid. Stop loss in health insurance refers to a type of insurance that provides coverage for catastrophic medical expenses, and may include services such as stop-loss insurance and reinsurance programs. Subrogation clause in health insurance refers to a provision in a health insurance policy that allows the insurance company to pursue reimbursement from a third party for medical expenses paid on behalf of a patient, and may include services such as subrogation clauses and reimbursement agreements. Supplemental insurance in health insurance refers to a type of insurance that provides additional coverage for medical expenses not covered by a primary health insurance policy, and may include services such as supplemental insurance and Medigap. Surgical services in health insurance refers to medical services that are provided in a surgical setting, and may include services such as surgical services and operating room services. Telehealth services in health insurance refers to medical services that are provided remotely through telecommunications technology, and may include services such as telehealth services and telemedicine. Termination date in health insurance refers to the date on which a health insurance policy is terminated, and may include services such as termination date and policy cancellation date. Therapy session in health insurance refers to a session of therapy or counseling, and may include services such as therapy sessions and behavioral health services. Third party in health insurance refers to an entity that is not directly involved in the provision of medical services, but may be involved in the payment or reimbursement of medical expenses, and may include services such as third-party administrators and

insurance companies. Urgent care in health insurance refers to medical care that is provided on an urgent basis, such as in an emergency room or urgent care center, and may include services such as urgent care and emergency services. Usual customary in health insurance refers to the amount of money that is typically paid for a particular medical service or treatment, and may include services such as usual customary and reasonable charges. Utilization review in health insurance refers to the process by which healthcare providers and insurance companies evaluate the necessity and appropriateness of medical services provided to patients, and may include services such as utilization review and case management. Vision care in health insurance refers to medical care that is provided for the eyes, and may include services such as vision care and eye exams. Waiver of premium in health insurance refers to a provision in a health insurance policy that waives the premium payment for a specified period of time, and may include services such as waiver of premium and premium waiver. Wellness program in health insurance refers to a program that provides incentives and rewards for patients to engage in healthy behaviors and preventive care, and may include services such as wellness programs and disease management. Workers compensation in health insurance refers to a type of insurance that provides coverage for work-related injuries and illnesses, and may include services such as workers' compensation and occupational health.