

Individual Health Insurance Glossary

Agent. An individual licensed by the state who sells insurance products and services to the public.

Annual Plan Deductible. A specific dollar amount that the insured must pay out-of-pocket each year before the insurance company will make any benefit payments for claims.

Applicant. The person applying for an insurance policy.

Benefit. Amount an insurance company pays to an insured person, assignee, or beneficiary when the insured suffers a loss covered by the insurance policy.

Benefit Options. Insurance benefits not included in the policy which are available to the individual as an option at an additional premium.

Claim. A request by the insured person or provider that benefits be paid on a covered health care service or supply.

Coinsurance. The payment percentage an insured is required to pay for a medical claim, apart from any copayments or deductibles. For example, if an 80%/20% arrangement is chosen, the insured pays 20% of the eligible covered amount and the insurance company pays 80%.

Condition. Disease, illness, ailment, injury, bodily malfunction, or pregnancy of an individual.

Copayment. A specific charge an insured person pays to a provider for a specific health care service at the time it is received. For example, an insured may pay a "\$35 office visit copay" according to the insurance policy.

Cost Sharing. The sharing of costs between the insurance company and the insured person through deductibles, co-insurance and co-payments.

Coverage. The benefits that are eligible under an insurance policy, depending on plan choices made by the applicant.

Effective Date. The date health insurance begins.

Eligible Expense. The portion of the medical care provider's services that is allowed for calculation of payment under the terms of the insurance policy.

Exclusion. Specific conditions, services or procedures listed in the insurance policy for which the insurance company will not provide coverage or benefit payment.

First-dollar Benefit. Eligible medical expense for which the insurance policy begins to pay claims without first requiring the insured to make an out-of-pocket contribution.

Lapse. Termination of an insurance policy due to non-payment of premiums.

Mandated Benefits. Benefits for medical conditions required by state or federal law to be included in health insurance policies.

Negotiated Fees. Service fees agreed upon by Preferred Provider Organizations (PPOs) and providers (doctors and hospitals). Rates are usually based on services as defined in the provider contract with the PPO, generally at a discount from what the provider would usually charge. Participating providers cannot charge more than this agreed upon amount.

Network Providers. Limited grouping or panels of providers in a PPO arrangement. Insureds may be required to use only network providers. There is additional liability to the insured for using non-network providers for medical services.

Out-of-pocket maximum (OOPM). The maximum amount that an insured is required to pay under an insurance policy per year.

Participating Provider. A provider who has agreed to contract with a PPO to provide services to covered persons at a discounted rate.

Renewal. Continuance of coverage under a policy beyond its original term by the insurance company's acceptance of the premium for a new term for the policy.

Pre-existing Condition. A health condition that existed before the effective date of the insurance policy.

Pre-existing Condition Clause. A provision in an insurance policy that outlines the definition of what is considered a pre-existing condition and that benefits are not paid for a pre-existing condition.

Premium. Periodic payment to keep an insurance policy in force.

Preventive Care. Specified wellness and health promotion services that are part of the benefits package of an insurance policy.

Reasonable and Customary. The maximum amount an insurance contract will consider eligible for reimbursement, based upon prevailing fees in a geographic area.

Rider (Exclusion). An amendment to an insurance policy that limits or excludes medical services or supplies. For example, a rider to a policy may exclude coverage for treatment to an applicant's knee.

Underwriting. The process of determining whether or not the insurance company will accept an insurance application or what conditions will not be covered along with any changes to the premium due to underwriting.

Sources: www.ahip.org, www.ehealthinsurance.com, www.nahu.org, www.kff.org, www.askme3.org

Questions? Celtic Consumer Sales Representatives are available to help. Simply call **(800) 779-7989** Monday-Thursday 8a.m.-5p.m. CST or Friday 8a.m.-4:15p.m. CST. Or send an e-mail to Info@celtic-net.com.



Celtic Insurance Company

233 S. Wacker Drive
Suite 700
Chicago, IL 60606

Consumer Sales Contact Information

Phone: (800) 779-7989
E-mail: Info@celtic-net.com

www.celtic-net.com

CELTIC



Celtic Insurance Company is a strong, committed, financially stable individual health insurance company specializing in quality individual health insurance. We aim to provide our customers with innovative, consumer-oriented products and services that are easy to understand, access and use.

Our plans offer our customers reliable, essential coverage while giving them control over their health care decisions. We have a wide-range of benefits and options to meet the diverse needs of people in rural, suburban and urban areas.

With the help of technology, we make our application process fast and easy, provide learning tools so individuals can choose the right plan and understand their benefits, quickly find providers, refill prescriptions and email customer service representatives all online.



Important Note: The information contained in this document and in any accompanying literature is not intended to provide full details of Celtic plans and may change at the discretion of Celtic Insurance Company. Complete terms of coverage are outlined in the individual Certificate Booklets and set forth in the applicable insurance Policy and Trust agreement.

In applying for coverage, the primary insured agrees to be bound by the Certificate. The benefits described in these pages and any accompanying literature are the standard benefits offered by Celtic. Policy provisions vary in some states. Plan availability and benefits may vary by state.

Celtic Insurance Company does not provide tax, investment or legal advice. Federal and state tax laws may change and are subject to interpretation. If tax, investment or legal advice is requested, consumers should seek the services of a licensed professional.

09/10
