



Basic Accident Insurance 101 – Terminology

I. Companies Servicing Your Insurance Coverage:

- Broker: a specialist in insurance and risk management that acts on behalf of their clients and provides advice in the interests of their clients.
- Insurer (often referred to as carrier or insurance company): the insurance company; the insurer underwrites the coverage and takes on the risk to cover a claim, receive the premium and may pay the claims if insurer does not hire a third-party administrator.
- Third-Party Administrator (TPA): an organization that processes insurance claims or certain aspects of insurance plans on behalf of an insurer.

II. Types of Insurance Plans:

- Health Maintenance Organization (HMO): an organization that provides health coverage with medical providers under contract. There is typically a penalty for utilizing providers that are not contracted providers.
- Preferred Provider Organization (PPO): a managed care organization of medical doctors, hospitals and other health care providers that have agreements with an insurer or a third party. There is typically a penalty for utilizing providers outside contracted providers.
- Participant Accident / “Basic Accident”: an insurance policy that is an excess accident medical policy that considers charges after all other valid and collectible insurance for injuries within the terms and conditions of the policy. This is the type of policy that could be purchased by your member institution to cover student-athletes’ athletically related injuries.
 - Fully Insured: an insurance policy where you pay a premium to an insurer and in turn claims are paid according to the terms and conditions of the purchased policy.
 - Aggregate: an insurance policy where a self-insured deductible level is set based on claim history with an insured layer if claims exceed the deductible.
 - Self-Funded: a self-insurance arrangement where an employer or organization provides insurance benefits with its own funds. The insured assumes the direct risk for payment of claims for benefits. The terms of eligibility and covered benefits are typically set forth in a plan document that includes provisions similar to those found in an insurance policy. Many times, the fund is administered by a third-party administrator at a fee of claims paid.
- NCAA Catastrophic Policy: an insurance policy purchased by the National Collegiate Athletic Association for all active member institutions that provides excess accident medical benefits for eligible injuries and additional benefits for defined disabling injuries.

III. Insurance Coverage Terms:

- Insurance Policy: a document detailing the terms and conditions of a contract of insurance.
- Insurer (carrier): defined above.
- Insured (claimant): a person or organization covered by insurance.

- **Premium:** the amount of money that an individual or organization must pay for coverage.
- **Deductible:** the amount an insured must pay before the insurance policy will make payment. Types:
 - **Aggregate Deductible:** a limit to the amount of deductible a policyholder will be required to pay on claims during a given period of time before insurance payment.
 - **Corridor Deductible:** the amount the insured must pay before insurance payment regardless of other insurance coverage.
 - **Reducing Deductible:** the amount the insured must pay unless the amount is reduced by other insurance payments.
- **Co-pay:** a flat fee an insured pays for certain covered services and prescriptions.
- **Coinsurance:** a percent of covered expenses the insured and insurer share after the deductible has been met.
- **Out-of-Pocket Maximum:** specific limits for the total amount insured will pay out of own pocket before coinsurance no longer applies.
- **In-Network:** providers or health care facilities that are part of a health plan's network of providers with which it has a negotiated discount.
- **Out-of-Network:** providers that are not contracted with the health plan for reimbursement at a negotiated rate. Services with an out-of-network provider may not be covered, or covered only in part, by the insurer.
- **Pre-authorization:** a health insurance requirement where a provider must contact the insurer/third-party administrator before service for approval of medical necessity.
- **Usual and Customary:** the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

IV. Insurance Claim Terms:

- **Explanation of Benefits (EOB):** a statement sent by an insurer/third-party administrator to the insured, explaining what/how medical treatments/services were considered by the insurer on their behalf.
- **UB04:** the standard billing form used for institutional facilities for billing that includes the medical coding necessary for an insurer to consider charges (i.e., hospital).
- **CMS1500:** the standard billing used for all non-institutional medical providers or suppliers for billing that includes the medical coding necessary for an insurer to consider charges (i.e., professional).
- **Statement:** a bill to the claimant stating the balance due. A statement does not typically provide required medical codes to consider charges.
- **“Superbill”:** an itemized statement used by health care providers that includes required medical codes for an insurer/third-party administrator to consider charges.
- **CPT Code:** the procedure code utilized by a medical provider to identify the services rendered.

- ICD10 Code: the diagnosis code utilized by a medical provider to identify the reason for the service.
- Tax ID Number (TIN): the provider identification number for billing and payment.
- Provider Agreements: agreements negotiated directly with medical providers for reduced fees associated with services.