CRANIOFACIAL CONDITIONS AND YOUR INSURANCE

Answers to questions about your coverage, your claims & your child’s rights

Washington Appleseed
SECOND EDITION
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Washington Appleseed is a non-profit organization working to address social and economic problems in our state by developing new public policy initiatives, challenging unjust laws, and helping people better understand and fully exercise their rights. We believe that by engaging both volunteer lawyers and community partnership these efforts, we better identify systemic problems, outline potential solutions, and achieve effective and lasting social change. Learn more at www.WaAppleseed.org.

Foster Pepper PLLC has a rich tradition of giving back to the community through pro bono advocacy. The firm’s attorneys dedicate their time and talent to cases and projects that change the trajectory of lives for the better and make the legal system accessible to all, not just those who can afford it. The firm receives its pro bono cases from leading non-profits, like Appleseed, and greatly values the opportunity to partner on important initiatives that provide systematic and positive change to the community at large.
Parents of a child with a craniofacial condition often encounter complicated insurance denial situations. This question and answer series, sample documents and glossary are meant to help families understand how the insurance system works and what care/treatment children with craniofacial conditions have a right to under their family’s insurance contracts.

This resource is not meant to replace or substitute legal assistance from an attorney about any specific problem; it is only an educational tool.

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What rights do I have under Washington State law about my health insurance?

Washington State has a Patient’s Bill of Rights that guarantees certain protections. These protections include:

- More transparent information about health insurance plans
- Access to a timely and unbiased appeal process when insurance carriers deny health care coverage
- The right to independent third-party review in ongoing disputes in an appeals process
- Safeguards from excessive invasions of privacy
- The right to seek damages when appropriate care is denied

Insurance carriers must provide you with documentation of benefits covered by your insurance plan, including what prescription drugs are covered. Insurance carriers must also notify you of any limitations, exclusions or reductions in coverage.

Insurance carriers in Washington State are required to have a fair grievance process that allows you to appeal a denied claim, also known as an adverse determination. When an insurance carrier makes an adverse determination, they must issue a written notice to the covered person and to any health care provider acting on behalf of the covered person. You can read more about having a health care provider act on your behalf in the section, “How do I increase the chances that my insurance claim will be accepted?” on page 8.

An adverse determination notification provided by the insurance carrier must include the following elements:

- the actual reasons for the adverse determination
- instructions for obtaining an appeal of the carrier’s decision
- a written statement of the medical reasons for their decision
- instructions for obtaining the clinical review criteria used to make the determination

You or your authorized representative have the right to appeal up to two times if there is an adverse determination. The initial appeal should be made in writing — a phone call is not
enough. The insurance carrier must reconsider the adverse determination, which includes reviewing all relevant information submitted by the covered person or the authorized representative acting on their behalf. If this appeal is rejected, you (the covered person) have the right to a second round of review, this time conducted by a certified independent third-party review organization.

Under Washington State law, an insurance carrier cannot prevent you from seeking judicial relief from an adverse determination, meaning that you have the right to bring a law suit against your insurance carrier. However, a judge can require that you first complete all of the appeals processes that the insurance plan allows. Remember that judicial remedies are expensive, and that there is no guarantee of success.

It is important to note that while Washington State law does guarantee residents certain rights, such as the right to appeal an adverse determination, the law does not guarantee you coverage by your insurance carrier.
Are there different types of health insurance? Are there different rights associated with these different types of insurance?

There are several different types of health insurance coverage available in Washington State. Some employer or employee groups purchase health insurance coverage from a commercial insurance company. Others may purchase group health coverage from a Health Maintenance Organization (HMO) or a Health Care Service Contractor (HCSC). These types of health insurance coverage are all regulated by the Washington State Office of the Insurance Commissioner and legal disputes with these insurance plans can generally be filed in state courts.

Some employer or employee groups provide “self-funded health benefit plans” or “union trusts.” For these plans, the employer or employee groups set aside funds to pay the health coverage claims submitted to the plan. Even though an insurance carrier may be hired to administer the benefits, the employer or employee group is responsible for the health care costs. This type of health insurance plan is governed by the Employee Retirement Income Security Act, or ERISA. Generally speaking, ERISA plans are governed by federal law, while non-ERISA plans are governed by state insurance regulations. ERISA pre-empts state law governing health insurance plans, meaning that if ERISA applies, then state law does not.

ERISA plans must provide written notice to any beneficiary whose claim for benefits is denied. This denial notice must be written in a way that the beneficiary can understand and must include the following information elements:

- the specific reasons the claim was denied and why they refuse to pay
- which specific plan provisions from the contract the denial is based on
- any additional information needed regarding the claim
- any appeal procedures or next steps you can take

You have a right to review all documents, records, and other information related to the decision. If your claim is denied, you should submit a written request for these documents because it will help you during your appeal.
ERISA plans must offer an opportunity to appeal an adverse determination. Like other governed by Washington State law, some ERISA plans must allow enrollees to appeal adverse determinations to an independent review organization. Other ERISA plans, known as *grandfathered ERISA plans*, are only required to offer an internal appeal process. If you have an ERISA plan, you should ask your insurance carrier whether you have the option to appeal the adverse determination to an independent review organization. Finally, you can also seek judicial relief if you are not satisfied with the final decision.

**How do I know what kind of health insurance I have and what is covered by my policy?**

In the previous question we outlined the different types of health insurance carriers that operate in Washington State. Those health insurance carriers cover things such as visits to the doctor’s office, physicals, immunizations, and inpatient surgery. You may also have dental insurance that covers routine dental exams and cleaning, fillings, and oral surgery.

Many people have medical insurance policies and dental insurance policies from different companies, and many people have one form of coverage but do not have the other. It is important to determine what kind of medical and dental insurance you purchased. Even if you get insurance coverage from your workplace you are the one “buying” your insurance coverage because it is thought of as part of your overall compensation for working.

Whether you buy your insurance yourself or your employer buys it for you as part of your pay, you should have received an *insurance benefits booklet* from your insurance carrier. If you do not have an insurance benefits booklet, there should be a phone number on your insurance card that you can call to request one for free. If you have an insurance *policy* through your employer, determine who

**REMINDER:** Your medical and dental insurance may be funded differently and have different processes for appeals. Make sure you know how each of your plans is governed.
in your Personnel or Human Resources department coordinates employee benefits; these individuals can provide basic information on your insurance plan and provide documents from your insurance carrier. Request the *Evidence of Coverage* document for both your health and dental insurance plans. Also request a copy of the *employee handbook*, if one is available at your workplace.

Once you have these documents, check to see if there are any exclusions. An exclusion is anything that the insurance plan will not cover, which may include certain procedures, drugs, or other treatments. Health insurance plans often contain exclusions for dental coverage and for *cosmetic services/surgeries*. If you have questions about a specific procedure or treatment, you can also call the customer service number on your insurance card for assistance.

It is important to know whether your insurance plan is governed by the state or if you have an ERISA plan because the information will help you determine the best way to advocate for your claim. When you enrolled in your insurance plan, your employer should have provided a *Summary Plan Description* that contains an explanation of how your insurance plan is funded, and whether state or federal laws protect your rights. If you do not currently have a Summary Plan Description, you can ask your employer to provide one for you. It is also recommended to consult with your Human Resources department or other staff who administer benefits to get more information regarding how your plan is funded.

If after talking to your employer you are still unclear whether your health coverage is governed by ERISA, you can contact the Washington State Insurance Commissioner for assistance at www.insurance.wa.gov/ or call toll-free at 1-800-562-6900.

**How do I know if a procedure is covered by medical insurance, dental insurance, or both types of insurance?**

Typically medical insurance and dental insurance are separate policies that cover different procedures. Unfortunately, many of the treatments that are required for craniofacial patients fall in the gray area between health insurance and dental insurance policies. These
treatments are often performed on patients without craniofacial conditions for dental or cosmetic reasons, but are performed on craniofacial patients in order to correct physical impairments and/or as a necessary precursor to additional treatment.

For example, the treatment plan for your child may include artificial teeth or dental prosthetics that replace missing teeth and related mouth or jaw structures. For a craniofacial patient, such dental prosthetics may be deemed a medical treatment and are often covered by medical insurance. However, some health insurers may reject claims for dental prosthetics because they put them in the category of dental treatment, which is often not covered.

Documents like your Evidence of Coverage, Summary Plan Document, and insurance benefits booklet will help you know if medical or dental insurance is more likely to cover your claim. Take a look at these documents for each type of insurance and make notes on any exclusions or limitations that might apply to procedures in your claim. Just because something is listed as limited or excluded does not mean you should not submit a claim; the exclusion might be listed because the procedure is typically cosmetic, but for your child it may be covered because it is medically necessary. If you are seeking coverage for a treatment or procedure that has a stated exclusion, you should include extra documentation to support your claim to increase your chances of receiving an approval (see more details in the section, “How do I increase the chances that my insurance claim will be accepted?” on page 8).

It is important to keep a copy of all correspondence with your insurance carrier. Records of phone calls, emails, and submitted claims can help you in the appeals process. For more information about organizational tools, see page 15.

It is important to know that you may submit the same claim to both your medical and dental insurance carriers. It is possible that each may cover part of the claim, and submitting it to both might increase your chances of having your claim covered.

Some insurance plans have case management services available, and these services assign people called case managers who help clients
navigate the insurance process, including helping sort out which insurance carrier you should send a claim to. Case managers track a child’s condition and can explain to you why certain types of care are being recommended. They also track a child’s condition and can work more quickly to understand the doctor’s request and figure out what the insurance company can do to review the problem. If you do not have a case manager, your child’s treatment team can help you to educate your insurance company about your child’s medical needs.

How do I increase the chances that my insurance claim will be accepted and my child’s medical/dental bills will get paid?

As discussed in the previous section, craniofacial patients encounter unique insurance claim scenarios, and you will likely need to take extra measures to successfully file a claim. To be on the safe side, you may want someone from your treatment team to act on your behalf. By authorizing someone from the staff to act on your behalf, that person becomes your representative and can help you in the claims process, for example, by helping to appeal an adverse determination that is made by the carrier. You can ask your child’s health care team if there is a standard authorization letter you can sign to allow the hospital or doctor’s office to act on your behalf and work with your insurance carrier.

The Evidence of Coverage provided by your insurance carrier explains the rules regarding submitting claims and gives you details about what will be covered by your plan. To increase your chances of having a claim accepted, follow the rules for your plan and be aware of special provisions like needing pre-authorization, or referrals, before seeking treatment. Remember to bring your insurance cards with you to all appointments.

The Office of the Insurance Commissioner also recommends, “Resolving questions first can prevent problems later. If you think a health care service may not be covered, or your company disagrees with your understanding of the policy, talk it over first with your provider and your insurer.”

The way you present a claim can also make your request more or less likely to be accepted.
In the following paragraphs, there are several suggestions for information to include in your insurance claim to increase your chances of success. Most insurance carriers have standard forms to complete when submitting a claim. If the forms allow, include the suggested information in the section where you can tell your story, also referred to as the narrative section. However, if there is no room for your side of the story on your claim forms, include a cover letter in addition to the standard forms.

The key to improving your chances of success is to stress in the claim that the procedure is *medically necessary*. In your narrative or cover letter, emphasize the functional results or ways in which your child’s day-to-day bodily functions will be improved by having a specific procedure. This includes things like being able to bite, chew, swallow, communicate/speak and breathe better. Show that the goal of the procedure is to bring the structure and function of an abnormal structure closer to what is considered to be normal. It is also advisable to briefly explain the underlying condition, and to explain how the particular procedure in question is a critical part of the child's overall treatment plan designed to address that condition.

Below is a sample of text explaining why a dental procedure should be considered medically necessary. Also see page 16 for a sample appeal letter to an insurance carrier.

[Name of procedure] is not a dental procedure, nor is it related to a dental condition — it is medically necessary to achieve basic chewing and swallowing functions for my child. My child's upper jaw is severely underdeveloped as a result of a bilateral cleft. This condition was not caused by any previous surgery and has been present since birth. Her jaw is not of normal size, nor will it grow to correct itself. Unlike someone with an overbite, my child cannot simply reposition her jaw at will to make her front teeth meet. It is impossible, and even painful to attempt.

As a result of the shape of her jaw, she has significant trouble chewing and food must be broken into tiny bites for her. She has to nearly swallow it whole. The physical challenges that prevent proper chewing make swallowing hazardous and she often chokes during meals. She has had so much trouble eating that she has been under the close care of a pediatrician for being underweight and for an inability to gain a healthy number of pounds. Without this medically necessary procedure, my child will never be able to bite, chew, or swallow normally. She will always have to eat with a chaperon present to assist her if she begins choking and face medical challenges associated with chronic malnutrition.
While the procedure discussed above may also have many other important benefits, such as improved appearance and self-esteem, avoid using these terms in your claim because they may make the procedure sound like it is for cosmetic purposes only. Your narrative or letter should make clear that the procedure is not for cosmetic purposes but instead that it is required so that the child can perform activities of daily living.

Most insurance carriers have detailed time-lines for how many days after receiving treatment a claim should be submitted. Submit your claim as soon as possible to avoid missing these deadlines. Retain a copy of all correspondence with your insurance carrier and health care providers, including claims submitted and any accompanying letters or documents. Make a note of the date you sent your claim, where you mailed it to and to whom you addressed it. See page 15 for suggestions on how to organize these details into a communication log.

What should I do if my insurance claim is denied?

The first step is to request the denial in writing if it has not already been provided to you. Under Washington State law, the insurance carrier must tell you why they will not pay for the treatment and provide you with the specific reason for their decision — you will need these specifics to effectively argue against their decision to not pay for the care.

The denial letter may also provide a contact person. If the letter does not mention a contact person, call the insurance company and request one. Ask for their direct line. If your insurance company offers case management services, ask that a case manager be assigned to your case.

As always, keep detailed records of all your contacts with the insurance company, including all letters or emails sent or received as well as a telephone log detailing with whom you spoke, his or her title, when the call took place, and the substance of the conversation. Keep a primary folder or three-ring binder with all of this information so that you can easily access and find it. Even if a conversation feels like it is not important, keep track of it in your contact log (see page 15 for details on creating a communication log).

The second step is to file an appeal. The exact appeal procedures are controlled by your
insurance plan, so refer to the Evidence of Coverage for specifics. The Evidence of Coverage will also detail important deadlines about the appeal procedure — make sure you understand the deadline structure and handle each step of the appeal within the allotted time-frame.

Appeal procedures may also be discussed in the denial letter. The specific regulations that govern the appeal will depend upon whether the plan is governed by state insurance regulations or by ERISA. Both Washington State regulations and ERISA guarantee certain procedural rights for beneficiaries; please refer to the section, “Are there different types of health insurance?” on page 4 for details. Including the following supporting information with your appeal letter is a good idea:

- A letter from your craniofacial/cleft team pediatrician explaining the importance and medical necessity of the specific procedure or treatment involved in the claim. A letter from your child’s Primary Care Physician or medical case manager outlining your child’s overall treatment plan may also be helpful. These letters should explain why the treatment plan is medically necessary for your child.
- Any pertinent information from your child’s medical records, such as photo documentation of the condition, records of doctor or emergency room visits resulting from complications with the condition, and any documentation of the total treatment plan for your child’s condition. Make sure you keep a copy of any materials you forward to your insurance carrier.
- Any articles from clinical journals that show the medical necessity of the procedure and/or otherwise support your case. You may want to discuss this with your doctor or specialist as he or she may be able to assist you.

If you submit a medical and dental claim for the same procedure, remember that each insurance carrier can cite different reasons for an adverse determination. Make sure to address the specific reasons the insurance carrier declined to pay your claim in your appeals.
It is important to keep track of all deadlines and to maintain a written record of how information is shared with the insurance company (phone, email, letter) and with whom it is shared (always get names and phone numbers of the people with whom you speak). See page 15 for suggestions on how to organize these details into a communication log.

If your first appeal is denied, think about what information might have been missing from your appeal packet and what additions you can make in your second appeal. Did you have a letter from your doctor and your specialist? Did you include articles from medical journals? Did you include information from your child’s medical records? Gather any missing information and resubmit all of the supporting documents associated with your appeal.

To increase the chances your claims and appeals will be accepted, make sure your paperwork is complete and all necessary supporting documents are attached. As you craft your narrative statement to support your request, make sure you answer questions like:

Why is this treatment medically necessary?

What proof do you have that it is medically necessary (like doctors’ letters, academic articles, etc.)?

Why is an exclusion or limitation defined by the insurance carrier not applicable to this particular set of circumstances?
What other resources are available to me?

**Washington State Office of the Insurance Commissioner** is a state office charged with consumer protection; in other words, they provide help to all citizens of Washington who have questions or concerns about their insurance problems. You can visit [www.insurance.wa.gov](http://www.insurance.wa.gov) to review general information about health insurance in Washington State or call **(800) 562-6900** for help with specific questions.

**The State Department of Labor** is the best resource for information regarding your rights under ERISA. You can access some of their publications via their website, [www.dol.gov/ebsa](http://www.dol.gov/ebsa). You may also request information by calling their publications hotline at **1-866-444-EBSA (3272)**.

**Cleft Advocate** is a helpful website, [www.cleftadvocate.org](http://www.cleftadvocate.org), with information from people who have dealt with insurance denials of their meritorious claims. There are examples of letters and help with understanding “insurance-speak.” The website helps to review the information that is directly related to craniofacial conditions. It is important to remember that all states have different laws and regulations about insurance, so sometimes the directions about what to do in your case will be somewhat different.

Alternatively, you may call **Aboutface USA**, which is now connected to Aboutface International, at **(416) 597-2229** or **(800) 665-FACE** or visit [www.aboutfaceinternational.org](http://www.aboutfaceinternational.org).

**Seattle Children’s Hospital Craniofacial Center** has a wonderful set of resources available on their website, [www.seattlechildrens.org/clinics-programs/craniofacial/resources/](http://www.seattlechildrens.org/clinics-programs/craniofacial/resources/).
Key documents you will need

A number of important insurance documents are mentioned in the preceding questions and defined in the glossary at the end of this booklet. Not every family will have every one of these documents, but most families will have many of them. These are the key documents you should locate and organize in one location so that you will be able to find and reference them as needed.

- Insurance benefits booklet
- Evidence of Coverage for both your health and dental insurance
- Employee handbook
- Summary plan description

Remember, you may request free copies of these materials from your employer or health insurance carrier.

Important deadlines to keep in mind

As previously discussed, meeting the deadlines outlined by your insurance carrier is key to successfully submitting a claim or appealing an adverse determination. Look through the materials listed in the “Key Documents You Will Need” section and make notes on any important time-line restrictions. Make sure you know the answers to questions like:

- How long do I have after a doctor visit, treatment or procedure to submit a claim?
- How long does it typically take to receive a determination on a claim?
- How long do I have after receiving an adverse determination to file an appeal?
- If I submit an appeal, how long do I have to continue submitting supporting evidence?
- How long does the insurance carrier have to respond to an appeal request?
- If my appeal is denied, how long do I have to file a second appeal?

Make notes on the answers to these questions and attach these notes prominently to your health care files. Consider keeping a calendar with these notes so that you can mark specific days that you must take action by to continue working through the claims process.
Sample communication log

It is suggested that you keep two journals or communication logs. In one, write down all communications you have with your insurance carrier and a second one where you write down your communications with health care providers. Your logs should include the name and title of the person you communicated with, the time and date of the communication, whether the communication was by phone, email, or letter, the substance of the communication, and what follow-up actions will be taken and the deadline when they will be taken by. Keep copies of all email and letters that you send and receive, including any attachments. It is a good idea to follow up a phone call with an email if you can, thanking the person for their help and summarizing the conversation. It is a good idea to keep copies of claims, supporting materials, and appeals in your logs too.

Here is a sample log entry with an insurance carrier:

<table>
<thead>
<tr>
<th>Name/Title of person contacted:</th>
<th>Sally Smith, customer service representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time and date of contact:</td>
<td>January 2, 2010; 5:00pm</td>
</tr>
<tr>
<td>Method of communication:</td>
<td>Email, <a href="mailto:sally.smith@aetna.com">sally.smith@aetna.com</a></td>
</tr>
<tr>
<td>Substance of communication:</td>
<td>I emailed her to let her know I wanted to appeal a denial of my insurance claim</td>
</tr>
<tr>
<td>Follow-up actions:</td>
<td>Waiting for her reply</td>
</tr>
<tr>
<td>Deadline:</td>
<td>Need to ask advocate</td>
</tr>
</tbody>
</table>

Here is a sample log entry with a health care provider:

<table>
<thead>
<tr>
<th>Name/Title of person contacted:</th>
<th>Ben Brown, clinic nurse @ hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time and date of contact:</td>
<td>January 2, 2010; 4:45pm</td>
</tr>
<tr>
<td>Method of communication:</td>
<td>Phone call, message left @ (206) 555-5555</td>
</tr>
<tr>
<td>Substance of communication:</td>
<td>Let him know I am appealing the denial of insurance coverage for surgery</td>
</tr>
<tr>
<td>Follow-up actions:</td>
<td>Will call back on 01/03/10 if no response</td>
</tr>
<tr>
<td>Deadline:</td>
<td></td>
</tr>
</tbody>
</table>
Sample appeal letter to your insurance carrier

[Insurance Company Name]
Attn: [Claims review department or the name provided in your adverse determination letter]
[Insurance Company Address]
[City, State, Zip code]

Re: [Name of the patient]
Patient Number:
Group Number:
Claim Number:
Procedure: [Name of procedure disputed in claim]

Date

To whom it may concern:

It is my understanding based on your letter dated [date of adverse determination letter], that our claim has been denied due to an “exclusion per your Evidence of Coverage”. After reviewing [cite the specific section of your Evidence of Coverage, such as: “Section 8—Exclusions, Paragraph 8.5”], I believe that this procedure should be covered.

While the determination letter concludes that the procedure should be classified as [“dental” or “cosmetic”], it is in fact a medically necessary treatment for a child with a craniofacial condition.

For my child, [name of procedure] is medically necessary to achieve basic chewing and swallowing functions. My child's upper jaw is severely underdeveloped as a result of [name of condition or specific problem to be addressed]. This condition was not caused by any previous surgery and has been present since birth. Her jaw is not of normal size, nor will it grow to correct itself. Unlike someone with an overbite, my child cannot simply reposition her jaw at will to make her front teeth meet. It is impossible, and even painful to attempt.

As a result of the shape of her jaw, she has significant trouble chewing — food must be broken into tiny bites for her and she has to nearly swallow it whole. The physical challenges that prevent proper chewing make swallowing hazardous and she often chokes during meals. She has had so much trouble eating that she has been under the close care of a pediatrician for being underweight and for an inability to gain a healthy number of pounds.

Without this medically necessary procedure, my child will never be able to bite, chew, or swallow normally. She will always have to eat with a chaperon present to assist her if she begins choking and face medical challenges associated with chronic malnutrition.

Based on Section 8, I am requesting on my child's behalf that you reconsider your previous decision and allow coverage for the procedure. The specialist for this treatment has written a letter supporting the medical necessity of the procedure in question. In addition, our [Primary Care Physician, Treating Physician, and/or Medical Case Manager] has written a letter outlining my child’s treatment plan, and you can see that this procedure is a necessary step towards overall health.

Should you require additional information, please do not hesitate to contact me at (XXX) XXX-XXXX or (cell) (XXX) XXX-XXXX.

Sincerely,

Your Name
[Mailing address]
[City, State, Zip code]

Enclosures: Original Claim documents [Date of claim]
Denial Letter [Date of denial letter]
Letter from Primary Care Physician
Letter from pediatric specialist
Article from [Journal name] on the necessity of [name of procedure]

cc: [Consider who should receive a copy of your appeal — your hospital, your case manager, your physician and your specialist, etc. List the names, titles, and associations of anyone receiving a copy of your appeal here.]
Glossary of common health insurance terms

**Adverse Determination:** Refusal by an insurance company/carrier to honor a request by an individual (or his or her healthcare provider) to pay for health care services obtained from a health care professional. Also known as a *denied claim*.

**Appeal:** A process for requesting a formal change of an official decision by an insurance carrier. Also known as a *rebuttal*.

**Authorized Representative:** A person or institution (such as a hospital) that you have formally given permission to act on your behalf or to advocate for you. Permission is usually given by signing a written authorization form.

**Benefits:** Benefits are medical services (such as an office visit, laboratory test, surgical procedure, etc.) or supplies (such as prescription drugs, durable medical equipment, etc.), that are included in a health insurance policy that you, the insured person, may receive. The “benefit” is the amount paid by the insurance carrier. The term “employee benefits” refers to extra goods or services an employee may receive from their employer aside from a direct paycheck and usually include things like health care, 401(k)s, or life insurance.

**Beneficiary:** The person receiving benefits from a health insurance carrier. Also known as a covered person.

**Claim:** A bill for medical services, typically submitted by a healthcare provider or you, the covered person, to the insurance carrier.

**Case manager:** An individual who works with the patient’s healthcare providers to assist in the management of the patient’s long-term needs, with appropriate recommendations for care, monitoring and follow-up. A case manager should also help ensure that the member’s health insurance benefits are being properly and fully utilized and that non-covered services are avoided when possible.

**Contract:** A written agreement between two or more people that creates obligations enforceable under the law. A health insurance contract typically includes the steps that are required to appeal an adverse determination.
Coverage: A health service which qualifies as a benefit under the terms of an insurance contract.

Covered Person: An individual who is eligible for specific benefits under a health insurance contract.

Cosmetic Services: Procedures that are usually used for improving a person’s appearance instead of for treating a medical condition. Cosmetic services are generally not covered by insurance carriers. See also cosmetic surgery.

Cosmetic Surgery: Surgery performed in order to improve the patient’s appearance and self-esteem; generally not covered by insurance carriers. See also cosmetic services.

Denied Claim: Refusal by an insurance company/carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional. Also known as an adverse determination.

Employee Handbook: A document provided by your employer detailing all benefit programs and eligibility requirements, including all benefits that may be required by law such as disability insurance, worker’s compensation, and COBRA. The handbook also details your options for health insurance plans.


Evidence of Coverage: A document that details the benefits and services paid for by the insurance plan, and explains the appeal procedures and applicable deadlines if a claim is denied.

Exclusion: Specific conditions, medical services or treatments that are not covered by an individual’s insurance policy and for which an insurance carrier will not pay.

Health Care Service Contractor (HCSC): Any corporation, cooperative group, or association, which is sponsored by or intimately connected with a health care provider or providers who or which accept prepayment for health care services in exchange for providing a person or groups of persons with any health care services.
Health Maintenance Organization: An HMO is a prepaid group health insurance plan that entitles members to services of participating physicians, hospitals and clinics.

Independent Third-Party Review: An impartial organization separate from your insurance carrier who will review your appeal of an adverse determination under certain circumstances.

Insurance Benefits Booklet: A summary document provided by your insurance carrier detailing the benefits covered by your insurance plan.

Insurance Carrier: A company that agrees to assume the risk of your loss and to compensate you for that loss. In the health insurance context, a health insurance carrier is a company that agrees to pay for procedures that are covered in your insurance contract.

Judicial Relief: The process of asking a court to grant the enforcement of rights or benefits. See also judicial remedy.

Judicial Remedy: A decision from the court. The remedy may be monetary (damages) and/or an injunction that orders a person or entity to perform a particular action.

Limitations: A limit or cap on the amount of benefits paid out for a particular covered expense, usually disclosed on the Certificate of Insurance or Evidence of Coverage.

Managed Care Organization: A health plan that manages health care delivery by having a defined network of select providers who contract to provide health care services to members. See also HMO and PPO.

Medically Necessary: Refers to procedures, treatments, medical supplies, or equipment that are appropriate and clinically needed. It is defined according to generally accepted principles of good medical practice. Medically necessary services or supplies are rendered for the diagnosis, care, or treatment of a medical condition.

The Office of the Insurance Commissioner: the entity that oversees the insurance industry to make sure that companies follow the rules and that Washington State consumers get what they pay for.
**Policy:** The legal agreement between an insurance company and insured person under which the insurance company agrees to pay for the covered medical services included in the agreement and the insured person agrees to pay the premium price.

**Preempt:** The principle that a federal law can take precedence over any inconsistent state law or regulation.

**Pre-existing Condition:** A physical or mental condition that is either previously diagnosed or which would require treatment prior to issuance of a new health insurance policy. New health insurance policies frequently do not cover pre-existing conditions for a specified period of time.

**Preferred Provider Organization (PPO):** A managed care option where members can choose to visit out-of-network providers, but as a result have to pay more.

**Premium:** Money paid by an insured person or business for a health insurance policy.

**Provider:** A provider can be a physician, hospital, medical care facility, or other type of medical personnel who provide health care.

**Reconstructive Surgery:** Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

**Reductions in Coverage:** A change in your insurance policy that decreases the level of reimbursement for specific treatments or procedures or eliminates coverage entirely. Notices of reductions in coverage are typically sent to covered persons in a letter from insurance carriers.

**Referral:** The process through which a patient under a managed care health insurance plan is authorized by his or her primary care physician to see a specialist for the diagnosis or treatment of a specific condition.

**To Act on Your Behalf:** An authorized individual or institution (such as a hospital) who acts in your stead. These individuals can negotiate with health insurance carriers.
or assist in submitting claims to the appropriate insurer. Traditionally, the individual or institution acting on your behalf have specialized skills that help them be effective in advancing your insurance claim.

**Self-Funded Health Benefits Plan:** This is a term that is used to describe a health plan where the employer assumes the risk for the cost of all covered health care services. Assuming the risk means that the employer funds the plan and pays for any services provided to the employee. Sometimes insurance companies are hired to help administer self-funded plans.

**Summary Plan Description:** A summary plan description is a document that tells employees covered by an insurance plan what the plan provides and how it operates. It provides information about when an employee can begin to participate in the plan, how service and benefits are calculated, when benefits becomes vested, when and in what form benefits are paid, and how to file a claim for benefits.
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