Index 1: Healthcare Insurance Providers in the US

1. UnitedHealthcare (UHC)
2. Anthem Blue Cross Blue Shield
3. Aetna (a CVS Health company)
4. Cigna Healthcare
5. Humana
6. Kaiser Permanente
7. Blue Cross Blue Shield Association (BCBSA)
    - Includes regional plans like:
        - Blue Shield of California
        - Independence Blue Cross (Pennsylvania)
        - Florida Blue
        - Highmark Blue Cross Blue Shield
8. Molina Healthcare
9. Centene Corporation
    - Includes plans like Ambetter, WellCare, and Health Net
10. Oscar Health
11. Bright HealthCare *(Note: Coverage varies by region and may be limited)*
12. HealthPartners
13. Tufts Health Plan *(New England area)*
14. Geisinger Health Plan *(Primarily in Pennsylvania)*
15. Harvard Pilgrim Health Care *(New England area*

Glossary

- **Allowed Amount / Contracted Rate** – The maximum amount an insurer agrees to pay for a covered service from an in-network provider.
- **Claim** – A request sent to the insurance to pay for medical services.
- **Coinsurance** – The percentage of costs a patient pays after the deductible is met (e.g., 20%).
- **Consumer-Directed Health Plans (CDHPs)** – Insurance plans that are often paired with tax-advantaged health accounts like HSAs to help manage high deductibles.
- **Coordination of Benefits (COB)** – How insurers decide which plan pays first when a patient has more than one policy.
- **Copayment (Copay)** – A set amount (e.g., $25) a patient pays for specific services like doctor visits or prescriptions. It does not require the deductible to be met and typically doesn't reduce it.

- **Deductible** – A patient must pay a specified amount each year before insurance starts covering services.
- **Durable Medical Equipment (DME)** – Medically necessary equipment like CPAP machines, oxygen tanks, or hospital beds.
- **Employer-Sponsored Insurance** – Health insurance coverage provided through an employer. The cost can be shared or fully covered by either the employee or the employer.
- **EPO (Exclusive Provider Organization)** – Requires use of in-network providers (except for emergencies), but typically does not require referrals.
- **Explanation of Benefits (EOB)** – A summary from the insurer showing what was billed, what was covered, and what the patient may owe. Not a bill.
- **FSA (Flexible Spending Account)** – A pre-tax account offered by employers to pay for eligible healthcare expenses. Funds are usually used-it-or-lose-it.
- **Formulary** – The list of medications covered by a health insurance plan.
- **Health Insurance** – A type of insurance that provides coverage for medical expenses due to illness or injury, whether current or future.
- **Health Maintenance Organization (HMO)** – Requires a primary care doctor and referrals to see specialists. Typically covers only in-network care.
- **Health Reimbursement Arrangement (HRA)** – An employer-funded account to reimburse employees for qualified medical expenses. Employees cannot contribute to it.
- **Health Savings Account (HSA)** – A tax-advantaged savings account used with high-deductible health plans (HDHPs) to pay for qualified medical expenses. Funds roll over and are portable.
- **High-Deductible Health Plan (HDHP)** – A plan with lower monthly premiums and higher deductibles, often paired with an HSA.
- **In-Network / Out-of-Network** – In-network providers have contracts with the insurer and offer discounted rates. Out-of-network providers typically cost more.
- **Insurance** – A form of financial protection that covers risk or future conditions in exchange for a premium.
- **Medicaid** – A government health insurance program for low-income individuals and families, administered at the state level.
- **Medicare** – A federal health insurance program for people 65 and older or with certain disabilities.
- **Medicare Advantage (Part C)** – A private insurance alternative to Original Medicare (Parts A and B) that often includes extra benefits. Enrollment requires Original Medicare.
- **Medicare Supplement (Medigap)** – Private insurance that helps cover costs not paid by Original Medicare (e.g., copays, coinsurance, deductibles). Cannot be used with Medicare Advantage.
- **Out-of-Pocket Maximum** – The most a patient will pay in a policy year for covered services. After reaching this amount, insurance covers 100%.
- **Patient** – The individual receiving medical care or treatment.
- **Payer** – The insurance company or government agency that pays for healthcare services on behalf of the patient.

- **Policy** – A legal contract between an individual and an insurance provider outlining coverage, terms, and conditions.
- **POS (Point of Service)** – Combines features of HMO and PPO plans. Requires referrals for specialists but allows limited out-of-network coverage.
- **PPO (Preferred Provider Organization)** – Offers flexibility to see in- or out-of-network providers. No referral is needed for specialists.
- **Preauthorization (Prior Authorization)** – Advance approval from insurance before certain procedures or medications are covered.
- **Premium** – The monthly fee paid to maintain health insurance coverage.
- **Provider** – Any healthcare professional or facility that delivers medical services (e.g., doctors, hospitals).
- **Provider Credentialing** – The process of verifying a provider's qualifications (education, licensing, training) to ensure they meet standards to deliver care and receive payment from insurers.
- **Referral** – A written order from a primary care provider for a patient to see a specialist, often required in health maintenance organization (HMO) plans.
- **Self-Pay** – When a patient pays directly for healthcare services without using insurance. Often involves negotiating costs and managing medical bills on your own.
- **Utilization Review** – An insurance process to determine if a requested healthcare service is medically necessary.