



Student Health Services

Insurance Common Knowledge and Information

The following common terms are often used by insurance companies to define policies, but this information is not meant to substitute the language used in your individual policy. Make use of the toll-free number on your insurance card to find out your policy benefits in detail from your insurance company.

Common Insurance Terms Defined

Benefits: Items and services that are covered by your insurance plan.

Claim: A bill to an insurance company

Co-insurance: The amount you are required to pay for medical care in a fee-for-service plan after you have met your deductible. The co-insurance rate is usually expressed as a percentage. For example, if the health insurance company pays 80% of the claim, you pay 20%.

Coordination of Benefits (COB): A system to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100% of the claim.

Co-payment: Another way of sharing medical costs. You pay a flat fee every time you receive a medical service (for example, \$20 for a visit to the doctor) and the health insurance company pays the rest. Be aware that for pharmacy charges, this expense occurs for every 30-day supply of medication. Getting a 90-day supply at once will require three co-payments.

Covered Expenses: Most health insurance plans, whether they are fee-for-service, HMO or PPO, do not pay for all services. Some may not pay for certain prescription drugs. Others may not pay for mental health care. Covered services are those medical procedures the insurer agrees to pay for; they are listed in the health insurance policy.

Coverage limits: Some health insurance policies only pay for health care up to a certain dollar amount. The insured person would be expected to pay any charges in excess of the health plan's maximum payment for a specific service.

Customary Fee: Most health insurance plans will pay only what they call a reasonable and customary fee for a particular service. If your doctor charges \$1,000 for a hernia repair while most doctors in the area charge only \$600, you will be billed for the \$400 difference in addition to the deductible and co-insurance you would be expected to pay. To avoid this additional cost, ask your doctor to accept your health insurance company's payment as full payment, or shop around to find a doctor who will.

Deductible: The amount of money you must pay each year to cover your medical care expenses before your health insurance policy starts paying.

Eligible Expense: The amount your insurance company considers qualified to be paid for a covered health benefit under your insurance plan.

Exclusions: Specific conditions or circumstances for which the policy will not provide benefits.

Explanation of Benefits (EOB): A statement—not a bill—sent by the health insurance company to the policy holder (student, parent or family member, depending on who bought the policy) explaining what medical treatment and/or services were paid for on their behalf. An EOB typically describes: 1) the service performed—the date of the service, the description and/or insurer's code for the service, the name of the person or place that provided the service and the name of the patient; 2) the doctor's fee and what the insurer allows—the amount initially claimed by the doctor or hospital, minus any reductions applied by the insurer; and 3) the amount the patient is responsible for.

Health insurance policy: Is a contract between an insurance company and an individual person, group plan/employer, or government programs (such as Medicare or Medicaid). Health insurance may provide coverage for medicine, visits to the doctor or emergency room, hospital stays and other medical expenses. Policies differ in what they cover, the size of the deductible, co-payment, or co-insurance.

HMO (Health Maintenance Organization): An HMO is a prepaid health plan. You pay a monthly premium and the plan covers doctors' visits, hospital stays, emergency care, surgery, checkups, lab tests, X-rays and therapy. You must use the doctors and hospitals designated by the HMO. Some insurance company policies may require you to change to a local primary care physician (PCP). Contact your insurance company for specific details.

In-Network: A health care provider that has a contract with your health insurance plan to provide health care services to its plan members at a pre-negotiated rate

Managed Care: Ways to manage costs, use and quality of the health care system. All HMOs and PPOs, and many fee-for-service plans, have managed care.

Maximum Out-of-pocket Expenses: The most money you will be required to pay per year for deductibles and co-insurance. It is a stated dollar amount set by the health insurance company, in addition to regular premiums.

Network Provider: Doctors, hospitals, and other health care professionals that have a contract with an insurance company, sometimes referred to as a “participating provider”.

Non-cancellable Policy: A policy that guarantees you can receive health insurance, as long as you pay the premium. It is also called a guaranteed renewable policy.

Open Enrollment: A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, individuals may be allowed to enroll in a plan outside of the open enrollment period in the event of a marriage, birth, death or divorce in their family.

Out-of-Network: a doctor or physician does not have a contract with your health insurance plan provider. This can sometimes result in higher prices.

Out-of-pocket: Money you pay out of your own pocket. Out of Pocket costs includes deductibles, copayments and coinsurance.

Out-of-pocket maximums: The most you have to pay in deductibles and co-insurance for covered health services during a plan year.

Pre-existing Condition: A health problem that existed before the date your health insurance became effective.

Preferred Provider Organization (PPO): A combination of traditional fee-for-service and HMO. When you use the doctors and hospitals that are part of the PPO, a larger part of your medical bills can be covered. You may use other doctors, but at a higher cost.

Premium: The amount you or your employer pays in exchange for health insurance coverage.

Primary Care Physician (PCP): Usually your first contact for health care, this is often a family physician or internist, but some women use their gynecologist. A primary care physician monitors your health and diagnoses and treats most health problems, and refers you to specialists if another level of care is needed. In many health insurance plans, care by specialists is only paid for if you are referred by your primary care physician. An HMO or PPO plan will provide you with a list of doctors from which you will choose your primary care physician (usually a family physician, internist, obstetrician-gynecologist or pediatrician), though PPOs allow members to use primary care physicians outside their PPO network at a higher cost. Indemnity plans cover services by any doctor. Some insurance company policies may require you to change to a local primary care physician (PCP). Contact your insurance company for specific details.

Prior or Pre-Authorization: The process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

Preventive medicine/care: Refers to measures taken to prevent diseases, illness or injury rather than curing them or treating their symptoms. This term also applies to care that is provided in which a person is otherwise considered well.

Provider: Any person (doctor, nurse or dentist) or institution (hospital or clinic) that provides medical care.

Subscriber: The policy holder.

Third-party Payer: Any payer for health care services other than you. This can be an insurance company, an HMO, a PPO or the federal government.