



STUDENT HEALTH SERVICES

Health Insurance Terms

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

Claim: A bill to an insurance company.

Coinsurance: Instead of, or in addition to, paying a fixed amount up front (a co-payment or deductible), the co-insurance is a percentage of the total cost that insured person may also pay. For example, the member might have to pay 20% of the cost of a surgery over and above a co-payment, while the insurance company pays the other 80%.

Coordination of Benefits (COB): Is the process of determining which of two or more insurance policies will have the primary responsibility of processing/paying a claim and the extent to which the other policies will contribute. COB is intended to prevent the duplication of benefits when a member is covered by more than one insurance carrier.

Co-payment: Is a flat fee the insured person must pay at the point of each health service visit. It does not accumulate like a deductible and is not subject to an out-of-pocket maximum.

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.

Deductible: The amount that the insured must pay each policy year to cover medical care expenses before the insurance policy starts paying. Deductibles are typically a set amount annually, but some plans require a deductible based on diagnosis rather than based on time.

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 a health insurance plan will not provide coverage. The insured is responsible for full dollar amount of the services rendered in such cases.

Explanation of Benefits: A document sent by a health plan to a covered person that explains how the insurance company processed the claim. The EOB lists the services provided, the amount billed, and the payment made. It must also explain why a claim was or was not paid, and provide information about the individual's rights of appeal. Keep in mind the EOB is not a bill.

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.

Health maintenance organization (HMO): A managed care plan that negotiates on healthcare premiums in return for limiting their physician and hospital visits to only network providers within their area. HMO's usually require a Primary Care Physician assignment to coordinate care, they have no out of area coverage except in an urgent care situation.

Managed care: A system of managing and financing health care delivery to ensure that services provided to managed care plan members are necessary, efficiently provided, and appropriately priced. They usually consist of HMOs (Health maintenance organization), PPOs (Preferred provider organization) and similar hybrids of the two.

Network Provider: Doctors, hospitals, and other health care professionals that have a contract with an insurance company, sometimes referred to as a "participating provider". Services provided by an In-Network Provider would be covered at a higher rate than a provider that was not contracted with the insurance company.

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-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 medical condition or injury that existed before the date your insurance went into effect.

Premium: The amount the policy-holder and/or his/her employer pays to the health plan to purchase health coverage.

Preferred provider organization (PPO): A managed care plan that contracts with network providers from which you can choose in or out of area. If you get health care from a provider that is not in the preferred network you may pay a higher amount.

Primary care physician (PCP): Is a physician who provides basic health care services and coordinates the delivery of all other health care for which benefits may be payable.

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.

Subscriber: The policy holder.