Health Insurance Terminology

**Accident**: An unexpected event that causes injury.

**Allowable Charges**: The charges agreed to by the Preferred Provider Organization (PPO) for specified covered medical treatment, services and supplies.

**Benefits**: The money the insurance company pays the health care provider for medical services provided to you if you become ill or injured.

**Claim**: A request by you for the insurance company to pay medical expenses that are covered under the insurance policy. If the provider of a medical service is in network, they will file the claim for you.

**Coinsurance**: A provision of the insurance by which the covered person and the insurance carrier share in a specified ratio of the eligible hospital or medical expenses resulting from a sickness or accident, (e.g. 80%:20%; the insurance carrier paying 80%, the insured person paying 20%). Coinsurance typically comes after the deductible, but not always.

**Coverage**: The conditions for which the insurance company will pay.

**Copayment**: A specified dollar amount a Covered Person must pay for specified services, typically for office visits, urgent care, and ER visits.

**Covered Person**: A Covered student and his or her dependent(s) insured under the Policy.

**Deductible**: The cumulative amount that you must pay annually before benefits will be paid by the insurance company. If the insurance policy indicates a "$250 deductible," the insurance company pays as agreed after you pay the first $250.

**Provider**: A licensed practitioner providing medical expertise and services within the scope of his or her license and practice.

**Effective Date**: The date insurance coverage begins.

**Eligible Expenses**: An expense defined in a health plan as being covered and not listed in the exclusions section.

**Essential Health Benefits**: A set of health care service categories that must be covered by certain plans, starting in 2014. The complete list of categories can be viewed at [HealthCare.gov](http://HealthCare.gov) - Essential Health Benefits.
Exclusions: Specified conditions or circumstances for which a policy does not provide benefits.

Expiration Date/ Termination Date: The date that insurance coverage ends.

Explanation of Benefits (EOB): The statement you receive from the insurance company showing the services, amounts paid by the plan and total for which you are being billed.

Identification Card: A card given to you that identifies you as a member of a particular health insurance plan. The card must be presented when seeking treatment, as it contains identifying information specific to you and your plan in order to process claims.

Insurance: A system under which individuals, businesses and other organizations, in exchange for a premium, are promised payments for losses resulting from certain dangers as specified in a contract.

Insurance Policy: The legal document issued by the company to the policyholder, which outlines the terms and conditions of the insurance; also called a "contract."

Insured: A person or organization covered by an insurance policy.

In-Network: Defines providers or health care facilities that are contracted with a particular network and have negotiated discounts with the participants of that network.

Major Medical: A plan that provides basic medical coverage, typically with a high deductible.

Medical Necessity/Medically Necessary: Services, supplies, or treatment for particular diagnoses that are within the standard of care in the medical community and/or as defined by CDC.

Open Enrollment: Time period when students are eligible to enroll or change coverage for any reason.

Out-of-Pocket Costs: The total you pay out of your pocket for a policy year. These costs include the deductible, co-insurance and amounts considered by the insurance company to be above the "Usual and Customary charges."

Out-of-Network: Defines providers or health care facilities that are not contracted with a particular network and do not have negotiated rates or discounts with that particular network.

Pharmacy: A business where drugs approved by a doctor are legally sold.

Pre-existing Condition: A medical condition that was diagnosed and/or required treatment during a fixed period of time, usually 3 or 6 months, before you purchased your insurance policy.
Preferred Provider Organization (PPO): A type of managed care health insurance plan that utilizes a network of physicians and facilities contracted by the insurance carrier to provide services for a negotiated price bound by contract. Utilizing PPO providers helps to keep the out of pocket costs lower to you overall and claims costs lower to the insurance plan.

Policy Term: The length of time a health policy provides benefits to a covered person.

Premium: The price you pay for your insurance policy.

Usual and Customary Charge/Reasonable and Customary: The routine charge for a medical service by similar professional medical providers in the same geographical area. You may be required to pay an amount above the Usual and Customary charge for an out-of-network provider, if that provider charges more than other providers for the same service.