“Health Insurance Terms 101”

University of Kansas
Watkins Health Services

When you’re navigating the world of health insurance, it’s crucial that you understand policy terminology and structures. Whether you’re buying insurance or working with your existing policy to get medical services paid, the language can be confusing at best, and, at worst – make you realize that the policy excludes anything you could ever need!

- Some definitions that may help clarify the muddy waters of health insurance –

Affordable Care Act (ACA): The federal law which regulates health insurance and makes coverage available to all persons. Law included expanding Medicaid to low income individuals.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A law requiring employers to offer continued health insurance coverage to employees who leave their employment. The employee must pay the entire premium for the coverage.

Co-insurance: Policy provision in which the insurance company and the patient share costs incurred after the deductible is met, according to a specific formula, e.g. insurer pays 80%, patient pays 20%.

Co-payment: Dollar amount that the patient must pay for certain covered services. Co-payments are often seen on physician office visits, emergency room treatment (if patient is not admitted to the hospital), or prescription drugs, e.g. $20 per office visit, $5.00 per prescription.

Covered Services: Health care services the insurance company will pay for under a specific plan.

Deductible: Amount of covered expenses that must be incurred by a patient, and paid for out-of-pocket, before benefits begin by the insurance plan, e.g. $500 per year.

EOB (Explanation of Benefits): Written statement from the insurance carrier with the date and nature of the healthcare services, the charges from the provider, any insurance payments made, and any amount the patient is responsible for paying.

Fee-for–Service: Traditional insurance in which patients may choose any doctor, regardless of specialty, at any time. Patient is responsible for all costs beyond those covered by the insurance plan.

Formulary: List of drugs covered by the insurance plan, generally includes both generic and brand-name drugs.

Lifetime Maximum: When benefits paid by an insurance plan reach this amount, no more will be paid for a patient under the plan.

Managed Care Organization: An organization or insurance carrier with health care plans (such as an HMO or PPO) focused on coordinating medical care through specific provider networks, regular review of care to assure necessity, and promotion of wellness to the people enrolled in the plan.

• **HMO (Health Maintenance Organization):** Contracts with a network (a group of physicians, other healthcare professionals and hospitals) to care for its patients for a flat monthly rate with no deductible. Only visits to professionals within the network are covered by the plan. All visits, prescriptions and other care must be cleared by the HMO in order to be covered. A primary physician within the HMO handles all referrals.

• **PPO (Preferred Provider Organization):** Made up of physicians, hospitals and other providers that provide medical care at a reduced fee. Similar to an HMO, but care is paid for as it is received instead of in a flat monthly fee. Visits to providers within the network require only a small fee. Offers more flexibility than an HMO by allowing patients to see doctors outside of the network without a referral, but often with a deductible and a higher co-payment.

Network: Group of physicians, hospitals, and other healthcare professionals/facilities that have agreed to provide services to patients of specific health plans. They further agree to accept the plan's reimbursement and not bill anything more to the patient.

Out-of-Pocket Maximum: Total dollar amount that an insured must pay each calendar year before an insurance plan will pay at the maximum rate. Includes the deductible and all co-insurance and/or co-payments.

PCP (Primary Care Physician): Physician specializing in internal medicine, family medicine, or pediatrics who coordinates all health services of a managed care patient and is responsible for making referrals for specialty care. Some plans may include obstetricians/gynecologists as primary care physicians.

Pre-Certification: Authorization from a Managed Care Organization for medical services before they are performed, such as seeing a specialist or admission to a hospital for elective or non-emergency procedures.

Pre-Existing Condition: Medical condition that exists before your health insurance policy begins. Generally, insurance payment for anything related to these conditions is excluded for a defined period of time, e.g. 6-12 months. Eliminated under ACA.

R&C or U&C (Reasonable & Customary or Usual & Customary Charges): Reimbursement calculation based on a defined geographic area. Based on what is "representative" for the area, it is used to reimburse providers for medical procedures.

Referral: Form provided by a Primary Care Physician authorizing a patient to receive services from another provider.

For More Information – Contact Watkins Health Services Insurance Office (785) 864-9520