

## UNIVERSITY STUDENT HEALTH SERVICES • Fact Sheet

## HEALTH INSURANCE TERMS

Trying to figure out what different health insurance policies offer can be like deciphering a foreign language. To understand the basics of health care coverage as well as the fine print, here is a glossary of common terms you should be familiar with. These terms and definitions are meant to be educational and may be used differently depending on the insurance plan.

- **Allowable Charge/Allowed Amount** – This is the amount of money that your insurance allows you to be charged for a visit, procedure, or medical supplies. Even if the provider bills a higher amount initially, you and your insurance company only have to pay the allowable charge.
- **Brand Name Medication** – This is a medication that is still under patent and can only be produced by the company owning the patent. Brand name medications are usually more expensive.
- **Co-Insurance** – This is your share of the allowable charge for a covered health care service. It is a percent and varies from policy to policy. For example, if the allowable charge is \$100, and your co-insurance is 20%, you will have to pay \$20. If your co-insurance is 50%, you will have to pay \$50.
- **Co-Pay** – This is the amount that you have to pay for each office visit. For example, you may have a \$25 co-pay to see your primary care provider and a \$40 co-pay to see a specialist.
- **Deductible** – This is the amount of money that you have to pay in medical expenses before your insurance begins to pay anything. If your health insurance policy has a \$3,000 deductible, you will have to pay \$3,000 towards your medical expenses before your insurance company begins to make payments.
- **Excluded Services, Noncovered Services** – These are services or procedures that your insurance company will NOT cover. These may be services that your insurance company deems as not medically necessary, experimental, or cosmetic. You will be financially responsible for the full cost of any excluded services you receive.
- **Explanation of Benefits (EOB)** – This is a summary that you will receive from your insurance company when they receive a bill for medical services. It will explain the allowable charge, how much they have paid, and the portion that you have to pay.
- **Formulary** – This is a list of prescription medications that your insurance company will pay for. This can vary greatly between policies. If you require special prescription medications, make sure that your medications are listed on your insurance company's formulary before purchasing that policy.
- **Generic Medication** – After a medication's patent runs out, any pharmaceutical company can produce the compound. The active ingredient in a generic medication is the same as in the brand name medication. Because the stabilizing chemicals that carry the active ingredient vary, the time to onset, peak blood level, and duration of action can be different from the brand name medication. This may have clinical significance, especially for seizure medications and some cardiac medications. Always ask your provider if a generic substitution is right for your condition.

- **Health Savings Account (HSA)** – This is money placed directly into an account from your paycheck. It can only be used for medical expenses—office visits, medications, procedures, eyeglasses, etc. The advantage is that the money you deposit into the account is not taxed. In some HSAs, the money is allowed to accumulate from year to year. In other HSAs, the account is reset to zero at the end of each year (in other words, use it or lose it). Talk with your employer’s benefits specialist to make sure you understand how their HSA operates.
- **In Network, Preferred Provider, Participating Provider** – These health care providers or facilities participate with your insurance company. Working with a network provider will give you the best price for a service.
- **Out of Network, Nonpreferred Provider, Nonparticipating Provider** – These health care providers or facilities do NOT have a contract with your insurance company. You may be responsible for the entire bill or have a higher co-insurance payment depending on how your policy is structured.
- **Out of Pocket Maximum** – This is the highest amount of money that you pay for covered services during the policy period (usually one year). Typically your insurance will cover 100% of your covered medical expenses after you have paid this amount; however, you must read the details of each policy to be certain.
- **Premium** – This is the amount of money that you pay each month for your health insurance policy.
- **Preventive Services** – These are health services that focus on the prevention of disease (e.g. vaccinations or counseling on smoking cessation) or screening to detect diseases early in their course (e.g. blood pressure screening or PAP smears).
- **Primary Care Provider (PCP)** – This is a doctor, nurse practitioner, or physician’s assistant who provides or manages the majority of your health care. The PCP provides referrals for specialist care when needed.
- **Prior Authorization, Pre-Authorization, Pre-Certification** – This is an extra approval process that some insurance companies require before they decide if they will pay for certain services, procedures, or medications.
- **Provider** – This is a trained medical professional who provides a service. It can be a physician, nurse practitioner, physician’s assistant, psychologist, physical therapist, podiatrist, etc.
- **Specialist** – This is a physician who has undergone fellowship training in a medical or surgical specialty. Some examples are cardiologists, endocrinologists, neurologists, and thoracic surgeons. Because of the extra training required of specialists, the co-pay for specialist visits are usually higher than the co-pay for primary care visits.