MEDICAL MUTUAL®

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Glossary of Health Insurance Terms

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This list defines many common healthcare terms you might not know. Knowing these terms can help you choose a plan that meets your needs. Some of these words are common with many types of insurance. This glossary explains what the words and phrases mean for health insurance.

Allowed Amount - The highest amount we will cover (pay) for a service.

Benefit Period - When services are covered under your plan. It also defines the time when benefit maximums, deductibles and coinsurance limits build up. It has a start and end date. It is often one calendar year for health insurance plans.
Example: You may have a plan with a benefit period of January 1 through December 31 that covers 10 physical therapy visits. The 11th or more session will not be covered.

Coinsurance - A certain percent you must pay each benefit period after you have paid your deductible. This payment is for covered services only. You may still have to pay a copay.
Example: Your plan might cover 80 percent of your medical bill. You will have to pay the other 20 percent. The 20 percent is the coinsurance.

Coinsurance Limit (or Maximum) - The most you will pay in coinsurance costs during a benefit period.

Condition - An injury, ailment, disease, illness or disorder.

Contract - The agreement between an insurance company and the policyholder.

Copayment (Copay) - The amount you pay to a healthcare provider at the time you receive services. You may have to pay a copay for each covered visit to your doctor, depending on your plan. Not all plans have a copay.

Covered Charges - Charges for covered services that your health plan paid for. There may be a limit on covered charges if you receive services from providers outside your plan's network of providers.

Covered Person - Any person covered under the plan.

Covered Service - A healthcare provider's service or medical supplies covered by your health plan. Benefits will be given for these services based on your plan.

Creditable Coverage - Coverage of a person under any of these:

- A group health plan. This includes church and governmental plans.
- Health insurance coverage.
- Medicare (Part A or Part B of Title XVIII of the Social Security Act).
- Medicaid (Title XIX of the Social Security Act, other than coverage consisting only of benefits under Section 1928).
- The health plan for active military personnel. This includes TRICARE.
- The Indian Health Service or other tribal organization program.
- A state health benefits risk pool.
- The Federal Employees Health Benefits Program.
- A public health plan (as defined in federal regulations).
- A health benefit plan under section 5 (c) of the Peace Corps Act.
- Any other plan which gives complete hospital, medical and surgical services.

Deductible - The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on your benefit period (typically a year at a time). Learn about deductibles here.
Example: If your plan has a $2,000 annual deductible, you will be expected to pay the first $2,000 toward your healthcare services. After you reach $2,000, your health insurer will cover the rest of the costs.

Dependent Coverage - Coverage for your dependents who qualify.

Emergency Medical Condition - A medical problem with sudden and severe symptoms that must be treated quickly. In an emergency, a person with no medical training and an average knowledge of health/medicine could reasonably expect the problem could:

- Put a person's health at serious risk.
- Put an unborn child's health at serious risk.
- Result in serious damage to the person's body and how his or her body works.

- Result in serious damage of a person's organ or any part of the person.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure - These are not approved by the U.S. Food and Drug Administration (FDA) or are not considered the standard of care.

FSA (Flexible Spending Account) - An FSA is often set up through an employer plan. It lets you set aside pre-tax money for common medical costs and dependent care. FSA funds must be used by the end of the term-year. It will be sent back to the employer if you don't use it. Check with your employer's Human Resources team. The can provide a list of FSA-qualified costs that you can purchase directly or be reimbursed for. A few common FSA-qualified costs include:

- Copays for doctors' visits, chiropractor and psychological sessions
- Hospital fees, medical tests and services (like X-rays and screenings)
- Physical rehabilitation
- Dental and orthodontic expenses (like cleaning, fillings and braces)
- Inpatient treatment for alcohol or drug addiction
- Vaccines (immunizations) and flu shots

HMO (Health Maintenance Organization) - Offers healthcare services only with specific HMO providers. Under an HMO plan, you might have to choose a primary care doctor. This doctor will be your main healthcare provider. The doctor will refer you to other HMO specialists when needed. Services from providers outside the HMO plan are hardly ever covered except for emergencies.

HRA (Health Reimbursement Account) - An account that lets an employer set aside funds for healthcare costs. These funds go to reimburse Covered Services paid for by employees who take part. An HRA has tax benefits for employer and employees.

HSA (Health Savings Account) - An account that lets you save for future medical costs. Money put in the account is not subject to federal income tax when deposited. Funds can build up and be used year to year. They are not required to be spent in a single year. HSAs must be paired with certain high-deductible health insurance plans (HDHP).

Health Assessment - A health survey that measures your current health, health risks and quality of life.

Inpatient Services - Services received when admitted to a hospital and a room and board charge is made.

Institution (Institutional) - A hospital or certain other facility.

Legal Guardian - The person who takes care of a child and makes healthcare decision for the child. This person is the natural parent or was made caretaker by a court of law.

Long-term Insurance - A type of health insurance that covers certain services over a set amount of time (typically a 12-month period).

Medical Care - Medical services received from a healthcare provider or facility to treat a condition.

Medically Necessary (or Medical Necessity) - Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:

- Accepted as standard practice. It can't be experimental or investigational.
- Not just for your convenience or the convenience of a provider.
- The right amount or level of service that can be given to you.

Example: Inpatient care is medically necessary if your condition can't be treated properly as an outpatient service.

Medicare - A federal program for people age 65 or older that pays for certain healthcare expenses.

Network Provider/In-network Provider - A healthcare provider who is part of a plan's network.

Non-covered Charges - Charges for services and supplies that are **not** covered under the health plan. Examples of non-covered charges may include things like acupuncture, weight loss surgery or marriage counseling. Consult your plan for more information.

Non-network Provider/Out-of-network Provider - A healthcare provider who is **not** part of a plan's network. Costs associated with out-of-network providers may be higher or not covered by your plan. Consult your plan for more information.

Outpatient Services - Services that do not need an overnight stay in a hospital. These services are often provided in a doctor's office, hospital or clinic.

Out-of-pocket Cost - Cost you must pay. Out-of-pocket costs vary by plan and each plan has a maximum out of pocket (MOOP) cost. Consult your plan for more information.

PPO (Preferred Provider Organization) - A type of insurance plan that offers more extensive coverage for the services of healthcare providers who are part of the plan's network, but still offers some coverage for providers who are not part of the plan's

network. PPO plans generally offer more flexibility than HMO plans, but premiums tend to be higher.

Prescription Drug - Any medicine that may not be given without a prescription because of federal or state law.

Premium - Payments you make to your insurance provider to keep your coverage. The payments are due at certain times.

Provider (Healthcare Provider) - A hospital, facility, physician or other licensed healthcare professional.

Short-term Insurance - A type of health insurance that covers certain services for a set time period (6 months or less). Learn more about short-term insurance.

Urgent Care Provider - A provider of services for health problems that need medical help right away but are not emergency medical conditions.

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