Defining Health Insurance Terms

The concept of health insurance is simple; you buy health care coverage and your carrier helps cover all approved health care costs. You may from time to time run into a health insurance term you're unfamiliar with. Some common misunderstood health insurance lingo, along with their definitions, can go a long way to helping you better understand your policy therefore making you a more informed consumer.

Benefits: You health insurance benefits refer to expenses covered by your health care plan and payments received by your health care professional from your insurance carrier.

COBRA: The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows participants of group health care programs through their job to receive benefits for a short period of time after leaving their employer. It also helps cover dependents/spouses if the policy holder dies or divorces them. This is especially helpful to those who are high risk or have pre-existing conditions since they can keep continual coverage until their new benefits are available.

Co-pay: Your co-payment, or co-pay, is the percentage or flat fee you're responsible for when you receive health care treatment. Your insurance carrier pays the remainder of the negotiated rate to your health care provider.

Deducible: Similar to your auto coverage, your deductible is the amount of money you're required to spend before your health care coverage takes over. Unlike your auto deductable, your health insurance deductable is usually met on an annual basis. Once it's met, you'll only be responsible for a fraction of your health care costs, is any at all.

Exclusions: Any health care expense not covered under your policy. This could be a condition, treatment, or medical equipment. Your exclusions will sometimes be referred to as riders as well.

Explanation of Benefits (EOB): Health insurance carriers will provide you with an itemized statement of what they've paid toward your appointment or procedure after each visit with your health care provider. This statement will also serve to notify you if you're responsible for any monitary amount left over once your insurance has paid the negotiated amount agreed upon; such as your co-pay or deductable. This statement is your EOB or Explanation of Benefits.

HIPAA: The Health Insurance Portability and Accountability Act (HIPAA) sets the standard of what, if any, of your personal and health care information can be shared without your consent. Your health care provider is responsible to provide every patient with their rights under HIPAA as well as answer any questions you may have about your privacy rights as they relate to you health care. HIPAA also governs complaints regarding personal and health care information released without consent.

HMO: An HMO (health maintenance organization) plan is a restricted network of hospitals and physicians covered by your health insurance. Under an HMO, you're usually required to choose a primary care physician and acquire a referral to see specialists from this primary care physician. Without a referral to a specialist, or if you visit an out of network physician, your visit will not be covered under your policy, and you will be required to pay for the visit.

Pre-existing conditions: If you're diagnosed with an ongoing or chronic condition prior to enrolling in your current health care coverage, this is a pre-existing condition.

PPO: A PPO (preferred provider organization) is also a network of health care providers but you're not required to choose a primary care physician, acquire referrals, and out of network providers are covered at a minimal benefit. A PPO policy is much more flexible than an HMO.