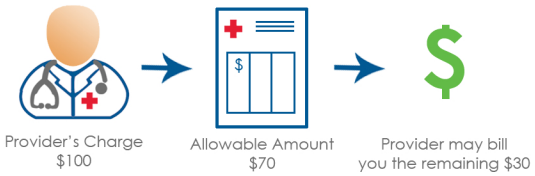
HSAC
HEALTH SCIENCES
Assurance Consulting, Inc.

Glossary of Health Insurance Terms
What you need to know.

Allowed Amount - Maximum amount insurance will pay for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

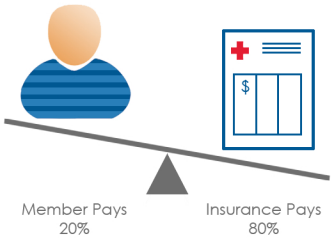
Appeal - A request for your health insurer to review a decision or a grievance again.

Balance Billing - When a provider bills you for the difference between the provider's charge and the allowed amount.



Co-insurance - Your share of the costs of a covered health care service. It is calculated as a percent of the allowed amount for the service. You pay co-insurance plus any deductibles you owe.

Example: If the health plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance plan pays the rest of the allowed amount.

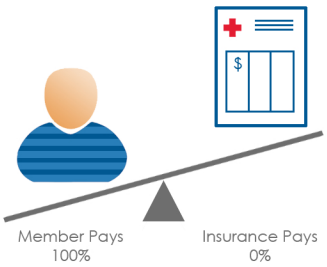


Complications of Pregnancy - Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

Co-payment - A fixed amount you pay for a covered health care service, usually when you receive the service. The amount varies by the type of covered health care service.

Deductible - The amount you owe for covered health care services before your health insurance begins to pay.

Example: If your deductible is $1000, your plan won't pay most benefits until you've met your $1000 for covered health care services. All healthcare services may not apply to the deductible.



Durable Medical Equipment (DME) - Equipment and supplies ordered by a healthcare provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition - An illness, injury, symptom or condition so serious that a reasonable person would seek immediate care to avoid severe harm.

Emergency Medical Transportation - Ambulance services for an emergency medical condition.

Emergency Room Care - Emergency services you get in an emergency room.

Emergency Services - Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services - Health care services that your health insurance or plan doesn't pay for.

Grievance - A complaint that you communicate to your health insurer.

Habilitation Services - Health care services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with injuries or disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance - A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care - Health care services a person receives at home.

Hospice Services - Services to provide comfort and support for persons in the last stages of a terminal illness.

Hospitalization - Care in a hospital that requires admission as an inpatient and usually requires an over-night stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care - Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance - The percent you pay of the allowed amount for covered health care services to providers who contract with your health insurance plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment - A fixed amount you pay for covered health care services to providers who have contracted with your insurance plan. In-network co-payments are usually less than out-of-network co-payments.

Medically Necessary - Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network - The facilities, providers and suppliers your health insurer has contracted with to provide health care services.

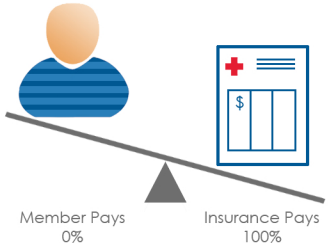
Non-Preferred Provider - A provider who doesn't have a contract with your health insurer to provide services to you. You may pay more to go to a non-preferred provider.

Out-of-network Co-insurance - The percent you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance plan. Out-of-network co-insurance may cost more than in-network co-insurance.

Out-of-network Co-payment - A fixed amount you pay for covered health care services from providers who do not contract with your health insurance plan. Out-of-network co-payments may be more than in-network co-payments.

Out-of-Pocket Maximum - The most you pay during a policy period before your health insurance begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance plan does not cover. Co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses count toward this limit.

Example: You have reached your out-of-pocket limit of $5000. Your plan will pay the full cost for covered health care services for the rest of the year.



Physician Services - Health care services a licensed medical physician provides or coordinates.

Plan - A benefit your college, university, employer, or other group sponsor provides to you for your health care services.

Preauthorization - A decision by your health insurer that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. May also be called prior authorization, prior approval or precertification. Your plan my require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance will cover the cost.

Preferred Provider - A provider who has contracted with your health insurer to provide services to you at a discounted rate. Check your plan to see if you can see all preferred providers or if your plan has a tiered network, asking you to pay extra to see some providers. Your plan may also refer to these as Participating Providers.

Premium - The amount that must be paid for your health insurance or plan. It is typically paid by semester for students.

Prescription Drug Coverage - The part of your health insurance plan that helps pay for prescription medications.

Prescription Drugs - Medications that by law require a prescription.

Primary Care Physician - A physician who directly provides or coordinates a range of health care services for a patient.

Primay Care Provider - A physician, nurse practitioner or physician assistant who provides, coordinates or helps a patient access a range of health care services.

Provider - A physician, health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery - Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services - Health care services that help a person keep, get back or improve skills for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical therapy, occupational therapy, speech-language pathology and psychiatric rehabiltiation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care - Skilled care services from licensed nurses, technicians, and therapists in your own home or in a nursing facility.

Specialist - A physician or specialist focused on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

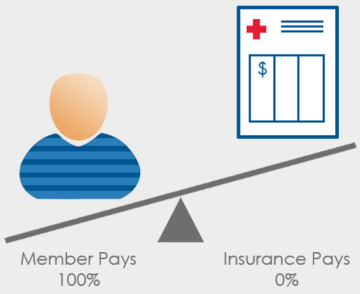
Usual, Customary & Reasonable (UCR) - The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount may be used to determine the allowed amount.

Urgent Care - Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How does Health Insurance Share the Cost of Health Care with You?

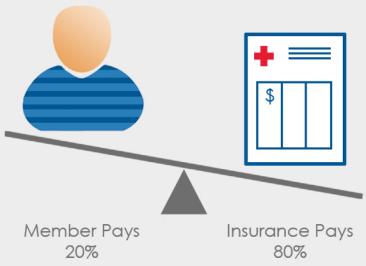
January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



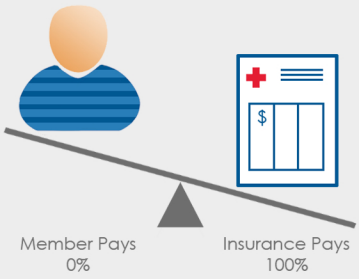
You have not reached your deductible yet. Your plan doesn't pay any of the costs for medical care. (In most plans doctor visits are a seperate category and charge only the co-pay)

Medical Care Cost: $100
You Pay: $100
Insurance Pays: $0



You have recieved care several times and have reached your deductible. Co-insurance begins and insurance pays some of the costs of your next visit for medical care. (Doctor visits continue to charge the co-pay)

Medical Care Costs: $100
You Pay: 20% of $100 = $20
Insurance Pays: 80% of $100 = $80



You have received care frequently and reached your out-of-pocket limit. Your insurance plan will pay the full cost of covered health services for the rest of the year. (Doctor visit co-pays will also be $0)

Medical Care Costs: $100
You Pay: $0
Insurance Pays: $100