Confusing Medical Insurance Terms Made Simple

When you are trying to find the most affordable medical insurance, you need to understand some basic terms so you know you are comparing apples to apples and coming up with accurate answers. Several terms are very commonly used in medical insurance policies that can reduce the confusion and make it much easier to choose the best coverage and most affordable health coverage available.

* Benefit - the amount the insurance company pays when the insured suffers a loss

* Benefit period - the benefit period is the amount of time involved in an individual claim. In the case of hospitalization, for example, the benefit period begins the first day of the hospital stay and ends when the patient is released from the facility. The benefit period will often extend for up to 60 days after release from a hospital or other qualified facility, counting any return to the facility as part of the original claim.

* Cafeteria Plan - a plan that offers a choice between two or more benefits or a choice between a benefit or cash

* Claim - a request by an individual or their provider to the insurance company to pay benefits for a loss

* COBRA - a federal law that allows employees to continue their insurance coverage, through self-pay, after it would normally terminate for up to 18, 24, 29 or 36 months. (COBRA insurance is generally expensive and not an affordable health coverage option for most people.)

* Co- Payment - a small charge the insured pays at the time medical service is received. Co-payments do not count toward deductible or out of pocket maximums.

* Deductible - the amount of covered expenses the insured must pay out of pocket before the insurance company pays. Choosing higher deductibles can help with affordable medical insurance premiums.

* Flexible Spending Accounts: special accounts typically funded by an employee's salary reduction to help pay certain expenses not covered by the employer's plan or insurance contract. The advantage of these accounts is that after-tax dollars are converted to before-tax dollars, thereby reducing the actual cost of expenses.

* Grace Period: time period that follows the premium due date when the coverage and policy remain in force.

* Health Maintenance Organization (HMO): a medical organization providing a wide range of widespread health care services for a specified group of enrollees for a fixed, pre-paid premium.

* Managed Care: coordination of financing and delivery of health care services to produce quality yet affordable health care coverage. Managed care puts limits on the use of services and the charges of providers.

* Out-of-Network Care: medical services obtained by managed care plan members from non-contracted health care providers. In many plans, such care will not be reimbursed unless the insured obtains previous authorization

* Out-of-Pocket Maximum: maximum dollar amount an insured is required to pay under a plan.

* Preferred Provider Organization (PPO): managed care arrangement consisting of a group of hospitals, physicians and other providers contracted with an insurer, employer or other group to provide health care services to covered persons in exchange for prompt payment and higher patient numbers.

While there are many other terms used throughout the medical insurance field, these are some of the ones you can

expect to find. Understanding these and other common insurance terms will help you determine the most affordable medical insurance for your individual needs.