

## GRA/GTA Statewide Student Insurance Plan

### Glossary of Terms

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The following terms and their definitions are a summary designed to assist you in understanding the provisions of your health insurance plan. The definitions are not meant to be all-inclusive. Wherever there is a conflict, the plan document legal definition prevails.

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**Allowable Charge** - the maximum amount a health plan determines is payable for a covered expense. Network providers and facilities are those who have agreed to accept the allowable charge for covered services under the plan. These are normally referred to as usual and customary charges.

**Coinsurance** - the percentage of covered medical expenses you must pay (in excess of the individual or family deductible) in addition to what your insurance plan pays for covered expenses. These amounts are called coinsurance because you and the insurance plan share the cost of health care expenses. Coinsurance usually applies after first meeting a deductible amount.

**Coinsurance Maximum** - the maximum amount you would pay in coinsurance each plan year before the insurance plan begins paying 100% of the allowable charge for covered expenses.

**Coordination of Benefits** - procedures used by insurance companies to avoid duplication of payments when a person has health insurance under more than one insurance plan. A coordination of benefits clause in either plan prevents double payments by making one plan the primary payer and the other a secondary payer.

**Copayment** - a fixed dollar amount established by the health insurance plan that you must pay in addition to what is paid by the insurance plan for covered expenses. This fixed amount is paid each time there is a covered service and does not add to the deductible and/or coinsurance requirements. Generally, there is no maximum associated with copayments.

**Covered Medical Expense** - an expense that is provided for and deemed medically necessary in the diagnosis or treatment of an illness or injury, performed and reimbursed in the least costly setting required by your medical condition.

**Deductible** - the amount you must pay each year toward covered expenses before the insurance plan begins paying any coinsurance. The amounts are accumulated to a specified dollar maximum.

**Exclusion** - a specific condition or circumstance for which the insurance plan or policy will not provide benefits.

**Explanation of Benefits (EOB)** - a statement sent to a participant by the health insurance plan listing services, amounts paid by the plan, and the total amount billed to the patient. This is not a bill and should be retained for claims reimbursement issues.

**Inpatient** - a situation in which services are provided to a patient who has been admitted to a hospital or other medical care facility.

**Medically Necessary** - services or supplies ordered by a physician or provider to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice prevailing in the medical specialty or field at the time the patient receives the service, and in the least costly setting required for the patient's condition. The service must be consistent with the patient's illness, injury or condition, and be required for reasons other than the patient's convenience. The fact that a physician or provider prescribes a service or supply does not necessarily mean it is medically necessary.

**Open Enrollment** - a designated period each semester during which an eligible GRA/GTA may enroll in a health insurance plan and add or drop eligible dependents to/from their health insurance plan without regard to any special eligibility situation.

**Out-Of-Pocket Maximum** - the most money you will be required to pay each plan year for deductibles, copayments and coinsurances. The amount is set by the health insurance plan.

**Outpatient** - services provided to a patient in other than an inpatient or medical care facility.

**Participating Provider** - a physician, hospital, pharmacy, or other medical facility that has contracted with the health insurance plan. Also called in-network or network provider.

**Plan Year** - for the State of Kansas GRA/GTA health insurance plan, it is from August 1 each year to July 31 the following year, on a semester by semester basis.

**Pre-Admission Certification** - assessment of medical necessity prior to actual hospital admission using established review criteria. Requires health insurance plan notification.

**Pre-Existing Condition** - any medical condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received by a licensed health care provider or practitioner within 180 days immediately prior to your effective date of coverage. The pre-existing exclusion is not applicable to pregnancy.

**Preferred Providers** - physicians, hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices.

**Premium** - the amount you pay in exchange for insurance coverage.

**Qualifying Event** - generally, an event that allows insurance coverage or an extension of insurance coverage for you, a spouse or dependent. Such events as marriage or birth of a child are qualifying events.

**Termination Date** - the date the health insurance policy ends.