Mason Health
Mason General Hospital • Mason Clinic

We understand that health care and health care insurance terms can be difficult for anyone. Without knowing the basics, it's hard to understand how things work.

With this brochure, we hope to give our patients more confidence when reading the information provided by health care insurance companies and on statements.

Here are some key terms to help you navigate the world of health care.

Mission

United Community,
Empowered People,
Exceptional Health

Vision

Provide the best
patient-centered care in the
Pacific Northwest

Values

Service & Relationships

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MASON CLINIC - HOODSPORT PRIMARY CARE
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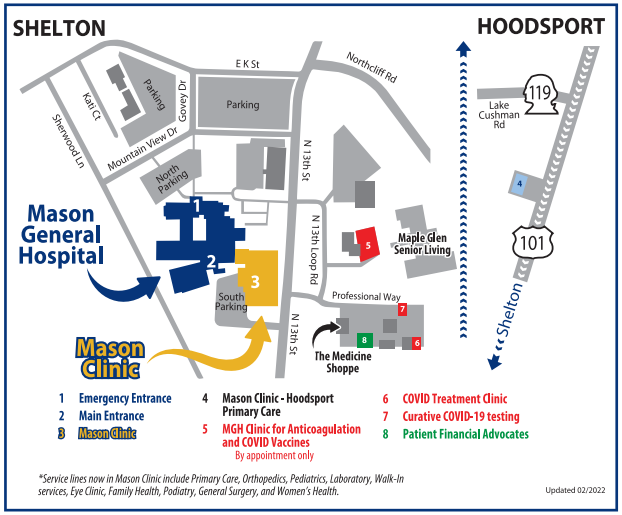

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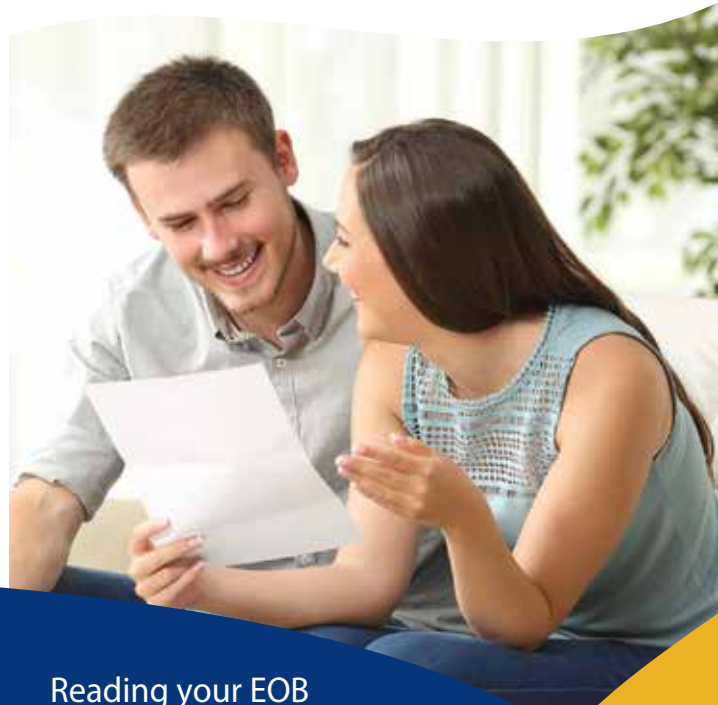
Common Health Care Insurance Terms



Reading your EOB
(Explanation of Benefits)
and other information

Common Health Care Insurance Terminology

ALLOWABLE CHARGES OR ALLOWED AMOUNT:

The maximum amount a plan will pay for a procedure, specific covered medical service or supply.

BILLED AMOUNT:

The amount of money a provider or supplier charges for a specific medical service or supply. This is often higher than the approved amount that your health plan and Medicare pay because insurance companies and Medicare negotiate lower rates for members.

CO-INSURANCE:

A percentage of the allowed amount you may be required to pay as your share of the cost for services. For example your insurance pays 80% and you pay 20%.

CO-PAYMENT:

A set or fixed dollar amount you are required to pay at the time a particular medical service is rendered..

CONTRACTUAL ADJUSTMENT:

The amount of charges a provider or hospital agrees to write off per the contract terms with the insurance company.

COORDINATION OF BENEFITS (COB):

When a patient is covered by more than one insurance plan. One insurance carrier is designated as the primary carrier and the other as secondary.

DEDUCTIBLE:

The amount that you must pay annually before benefits will be paid by the insurance company. If the insurance policy indicates a $250 deductible, the insurance company pays as agreed after you pay the first $250.00 for qualifying expenses.

EXPLANATION OF BENEFITS (EOB) OR EXPLANATION OF PAYMENT (EOP):

The statement you receive from the insurance company showing the services, amounts paid by the plan and total for which you are being billed. Your insurance company is required to provide this to you. Medicare EOPs are mailed quarterly or available on line.

HEALTH MAINTENANCE ORGANIZATION (HMO):

In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list, except in an emergency. With an HMO, you select a primary care physician (PCP) who is in the plan's network.

MEDICARE PART A:

Covers inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.

MEDICARE PART B:

Covers certain doctors' services, outpatient care including Emergency Room, medical supplies, and preventive services.

MEDICARE PART C (MEDICARE ADVANTAGE PLAN):

A type of Medicare health plan offered by a private company that contracts with Medicare to provide all of your Part A and B benefits. If you're enrolled in a Medicare Advantage Plan, services are covered through the plan and aren't paid for under original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

MEDICARE PART D (PRESCRIPTION DRUG COVERAGE):

This is optional coverage offered by insurance companies and other private companies approved by Medicare.

NON-COVERED CHARGE/EXCLUSIONS:

Conditions under which the insurance company will not pay; for example, cosmetic procedures are often exclusions. These then become patient responsibility.

NON-PREFERRED PROVIDER:

A provider who doesn't have a contract with your health plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if a provider is contracted with your health plan.

OUT-OF-POCKET COST:

The total you pay out of your pocket for a policy year. These costs include the deductible and co-insurance.

PATIENT RESPONSIBILITY:

The amount a patient is responsible for paying that is not covered by the insurance plan.

PREFERRED PROVIDER:

A provider who has a contract with your health plan to provide services to you at a discount.

PREMIUM:

The amount the insured or their employer pays (usually monthly) to the insurance company for the insurance policy.

PREVENTIVE SERVICES:

Covered services that prevent or detect illness and do one or more of the following: Protect against disease and disability or detect disease in its earlier states before noticeable symptoms develop.

SERVICE CODE/DESCRIPTION:

Standard health care industry codes used to bill insurance companies for services. Next to each code is a shortened description of the service - for example, "office visits;' "lab work;" or "surgery."

SUMMARY OF BENEFITS AND COVERAGE:

A plainlanguage summary of your benefits and coverage. In compliance with the ACA, every insurer must supply this document and a uniform glossary of common health terms to members and prospective members during open enrollment or upon request.

Please contact your insurance company directly with any specific questions about your plan benefits.