Health Insurance Terms

Allowed Expenses: The maximum amount a plan pays for a covered service. See Usual and Customary Charges.

Benefits: Medical services for which your insurance plan will pay, in full or in part.

Capitation: A flat monthly fee that a health plan pays to a provider (doctor, hospital, lab, etc.) to take care of a patient's needs. Capitation is part of the provider-reimbursement mechanism.

Claim: A notice to the insurance company that a person received care covered by the plan. A claim also may be a request for payment and will state so.

Co-insurance: A term that describes a shared payment between an insurance company and an insured individual, usually described in percentages. For example, the insurance company agrees to pay 80% of covered charges and the individual picks up the remaining 20%.

Coordination of Benefits: A system to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100 percent of the claim.

Co-payment: The insured individual's portion of the cost, usually a flat predictable dollar amount, such as $10 per office visit. Under many plans, co-payments are made at the time of the service and the health plan pays for the remainder of the fee. Generally, a plan will either require co-payments without a deductible, (HMO, POS plans) or co-insurance and a deductible, (indemnity, PPO plans).

Coverage: What the health plan does and does not pay for. Coverage includes almost everything mentioned in this booklet: benefits, deductibles, premiums, limitations, etc.

Covered Expenses: What the insurance company will consider paying for as defined in the contract. For example, under some plans generic prescriptions are covered expenses, while brand name prescriptions may be covered at a different reimbursement rate or not at all.

Deductible: A portion of the covered expenses (typically $100, $250 or $500) that an insured individual must pay before benefits are paid by the insurance plan. Deductibles are standard in many indemnity and PPO policies, and are usually based on a calendar year.

Exclusions: Specific conditions or circumstances for which the policy will not provide benefits.

HMO (Health Maintenance Organization): Prepaid health plans. You pay a monthly premium and the HMO covers your doctors' visits, hospital stays, emergency care, surgery, checkups, lab tests, x-rays, and therapy. You must use the doctors and hospitals designated by the HMO.

Managed Care Plan: A term that typically refers to an HMO, Point of Service, EPO, or PPO; any health plan with specific requirements, such as pre-authorization or second opinions, which enable the primary care physician to coordinate or manage all aspects of the patient’s medical care.

Maximum Out-of-Pocket: The most money you can expect to pay for covered expenses. The maximum limit varies from plan to plan. Some companies count deductibles, co-insurance, or co-payments toward the limit, others don't. Once the maximum out-of-pocket has been met, many health plans pay 100% of certain covered expenses.

Noncancellable Policy: A policy that guarantees you can receive insurance, as long as you pay the premium. It is also called a guaranteed renewable policy.

Open Enrollment: A specified period of time in which employees may change insurance plans and medical groups offered by their employer, without proof of insurability. Open enrollment usually occurs once a year.

PPO (Preferred Provider Organization): A combination of traditional fee-for-service and an HMO. When you use the doctors and hospitals that are part of the PPO, you can have a larger part of your medical bills covered. You can use other doctors, but at a higher cost.

Pre-existing Condition: Unfortunately, there's no clear-cut definition of this term; each insurance company has a different way of looking at it. Generally speaking, it's a medical condition that was first treated or has manifested itself prior to your enrollment in a plan. Some plans completely exclude pre-existing conditions from coverage; others may have a waiting period of six months to a year. You should check the plan carefully or talk to your insurance agent if you think you may have such a condition.

Pre-authorization: An insurance plan requirement in which you or your primary care physician must notify your insurance company in advance about certain medical procedures (like outpatient surgery) in order for those procedures to be considered a covered expense.

Premium: The money paid to an insurance company for coverage. Premiums are usually paid monthly and may be paid in part or in full by your employer.

Primary Care Physician (PCP): Under many plans, you'll be asked to designate a family practice doctor, pediatrician or an internal medicine physician as your primary care physician (PCP). The PCP is responsible for coordinating all of your care. Any referrals to a specialist must first be approved by your PCP in order to be considered a covered expense. Note: some plans also allow you to choose an OBGYN as your PCP.

Provider: The supplier of health care services. This could be a physician, hospital, physical therapist, etc.

Specialist: A physician who practices medicine in a specialty area. Cardiologists, orthopedists, gynecologists and surgeons are all examples of specialists. Under most health plans, family practice physicians, pediatricians and internal medicine physicians are not considered specialists. Some health plans require preauthorization from your primary care physician before you can see a specialist.

Third-Party Payer: Any payer for health care services other than you. This can be an insurance company, an HMO, a PPO, or the Federal Government.

Usual and Customary Charges: The average cost of a specific medical procedure in your geographic area. This is the maximum amount some insurance companies will pay for certain covered expenses. Also referred to as allowed expenses, they reflect the provider's retail cost of service. For example, the actual fee for open-heart surgery may be more than your plan's usual and customary charges. In that case, you would be responsible for the difference, and the amount you pay would be applied to your maximum out-of-pocket.