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Health and wellness tips for your work, home, and life—brought to you by the insurance and healthcare specialists at Propel Insurance.

Health Insurance Terms You Need to Know

The health care system in the United States can be complex and confusing. In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, health plans, and health care providers. This way, you can make better decisions – ultimately receiving better care.

Ambulatory Care – Health care services that do not require a hospital stay, such as those delivered in a doctor's office, clinic, or day surgery center.

Assignment of Benefits – This is signing a document allowing your hospital or doctor to collect your health insurance benefits directly from your health carrier. Otherwise, you pay for treatment and the insurance company reimburses you.

Benefits – The amount of money payable by an insurance company to a claimant under the insurance policy.

Capitation – Represents a set dollar limit that a health maintenance organization (HMO) pays to your primary care physician for providing medical treatment to you and your dependents. The fee is usually paid to the physician on a monthly basis. The physician gets no more or less than this set fee, no matter how much or how little you use his or her services.

Case Management – A technique that insurance companies and HMOs use to ensure that individuals receive appropriate, timely, and reasonable health care services.

Claim – A request by an individual (or his/her provider) for the insurance company to pay for services obtained.

Coinsurance – The money that an individual is required to pay for services, after a deductible has been paid. In some health plans, coinsurance is referred to as "copayment." It is often a specified percentage of the charges. For example, the employee pays 20% of the charges while the health plan pays 80%.

Copayment – An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered. The concept is similar to coinsurance, except that copayments are usually a set dollar amount (such as $20 per office visit), rather than a percentage of the charges.

Deductible – A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual basis.

Denial of claim – Refusal by an insurance company to pay a submitted request for health care services obtained.

Employee Assistance Program (EAP) – Mental health counseling services that are sometimes offered by insurance companies or employers. Typically, individuals or employers do not have to pay directly for EAP services provided.

Exclusions and limitations – Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations.)

Health Maintenance Organization (HMO) – Prepaid, or capitated, health care plans in which individuals pay a small monthly fee to be a member of the HMO, as well as small fees or copayments for specified health care services. Services are provided by physicians and allied health care personnel who are employed by or under contract with the HMO. HMOs are available to both individuals and employer groups.

Indemnity plans – Also known as "fee-for-service" plans. These existed primarily before the rise of HMOs and PPOs. The individual pays a predetermined percentage of the cost of health care

services, and the insurance company (or self-insured employer) pays the other remaining charges. Fees for services are determined by individual providers, and therefore vary from physician to physician. Indemnity health plans allow individuals to choose their own health care professionals – there are no provider networks from which to choose.

Independent Practice Association (IPA) – A group of independent practicing physicians who band together for the purpose of contracting with HMOs, PPOs, and insurance companies for their services.

In-Network – Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.

Long-term Care Insurance – Insurance policies that cover the costs of providing nursing care, home health care services, and custodial care for the aged and infirm.

Managed Care – A system of health care delivery that is characterized by arrangements with selected providers, ongoing quality control and utilization review programs, and financial incentives for members to use providers and procedures covered by the plan.

Maximum Benefit – The maximum dollar amount that an insurance company will pay for claims, either for a specific service or procedure, or during a specified period of time.

Medically Necessary – A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.

Out-of-Network – Typically refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.

Out-of-Pocket Maximum – The total amount paid each year by the member for the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that calendar year.

Point-of-Service Plan (POS) – A type of HMO that allows the patient to see either in-network or out-of-network providers. However, the patient pays more out of pocket when using an out-of-network provider.

Pre-admission Certification – Also called "precertification" or "pre-admission review." Approval granted by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or inpatient facility before admittance. The goal is to ensure that individuals are not exposed to inappropriate health care services, or services that are not medically necessary.

Pre-existing Condition – Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.

Preferred Provider Organization (PPO) – A type of managed care plan in which doctors and hospitals agree to provide discounted rates to plan members. Patients are typically reimbursed 80-100% for treatment received within the network, versus 50-70% outside the network.

Primary Care Physician (PCP) – A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a gatekeeper for an individual's medical care, referring him or her to specialists and admitting him or her to hospitals when needed.

Reasonable and Customary Charges – The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges then are the responsibility of the patient.

Self-Insured – A health benefits plan in which the employer is at risk for the cost of its employees' health care. Typically, a third party provides administrative services for the plan to the employer group.

Waiting Period – A period of time in which your health plan does not provide coverage for a particular pre-existing condition.

Waiver – A rider or amendment to a policy that restricts benefits by excluding certain medical conditions from coverage.

Did you know...?

A Federal law makes it possible for most people to continue their group health coverage for a period of time after leaving a job. This option is called COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). You can continue to receive coverage for up to 18 months, but will be paying the full premium.

This brochure is for informational purposes only and is not intended as medical advice. For further information, please consult a medical professional.