

Definitions for Commonly-Used Health Insurance Terms¹

Below are some commonly-used health insurance terms. We recommend familiarizing yourself with these terms and their meanings before purchasing health insurance for you or your family.

Coinsurance

The portion of covered healthcare expenses that must be paid by the policyholder in addition to the deductible. This figure is usually expressed as a percentage. For example, in a traditional 80/20 plan, the insurer pays 80 percent of the doctor's bill and the patient pays 20 percent. This is based on the insurance company's definition of what constitutes a physician's "reasonable and customary" fee.

NOTE: Many physicians' charges are higher than the "reasonable and customary" fee and the patient is responsible for 100 percent of the excess amount. This is known as "balance billing." Some insurance companies have special agreements with physicians and hospitals in which they agree to accept the "reasonable and customary" fee as payment in full. This means you never pay more than your applicable coinsurance.

Copayment

The dollar amount a managed care patient pays when services are received. For example, there may be a \$10 copayment due each time you visit your primary care physician and a \$20 copayment for a specialist visit. Prescription drug programs often have copayments also. For example, you might pay a \$10 copayment for generic drugs and a \$20 copayment for brand-name drugs.

Covered Services

Applies to services or supplies specified in the contract for which benefits are available under the member's plan.

Deductible

The amount a person must pay before the insurance company begins to pay its portion of claims. In general, the higher the deductible, the lower the premium of the health plan.

Health Maintenance Organization (HMO)

A type of health benefits program that usually has the lowest out-of-pocket costs. HMOs agree to provide all of the health care for you and your family members in exchange for a fixed, monthly premium and low per-visit copayments. HMOs require you to select a primary care physician, generally a family practitioner, internist or pediatrician, who is part of their network. There are generally no deductibles, small copayments and no claims to file. A referral from your primary care physician is required to see a specialist other than an OB/GYN.

Indemnity or Fee-for-Service Plans

Medicine the old-fashioned way. Patients receive a bill from their doctor or hospital for each service rendered. They submit their bill to their insurance company and the company pays it. Some insurance companies have special arrangements with many physicians and hospitals to submit their claims directly to the insurance carrier on behalf of the patient, which saves you time. Indemnity or fee-for-service plans provide the maximum choice of physicians and hospitals but are generally the most expensive kinds of plans.

¹ This information is courtesy CareFirst BlueCross BlueShield, and is available at [http://notesnet.carefirst.com/ecommerce/glossacrony.nsf/\\$\\$viewtemplate+for+vwinternetglossary?OpenForm](http://notesnet.carefirst.com/ecommerce/glossacrony.nsf/$$viewtemplate+for+vwinternetglossary?OpenForm). Please refer to this website for more definitions of commonly-used health insurance terms.

Managed Care

A general term for organizing doctors and hospitals into healthcare delivery networks with the intent of lowering costs and "managing" the medical care provided. HMOs were the earliest form of managed care. Today there are many different kinds of plans, including PPO plans.

Network

A selected group of physicians, hospitals, laboratories and other health care providers who participate in a carrier's health delivery program and agree to follow the plan's procedures.

Out-of-Pocket Limit or Out-of-Pocket Maximum

A limit on all of the insured's out-of-pocket expenses (including deductibles and copayments) for treatment of illness or injury. When the maximum is reached, the insurance company will begin covering 100 percent of eligible charges.

Preferred Provider Organization (PPO)

A managed care plan that doctors and hospitals agree to participate with at discounted rates. PPOs usually have fewer administrative rules than HMOs. For example, they usually don't use primary-care physicians to coordinate patient care. Patients are reimbursed 80 percent to 100 percent for treatment within the PPO versus 50 percent to 70 percent outside of it.

Premium

The monthly payment you make for health insurance coverage. It does not include any deductibles or copayments the plan may require.

Primary Care Physician (PCP)

A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist or pediatrician.