

Glossary of Health-care and 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 in Health Maintenance Organizations (HMO) and some Point of Service (POS) plans.

Claim: A notice to the insurance company that a person received care covered by the plan. A claim also is a request for payment.

Co-insurance: A term that describes a shared payment between an insurance company and an insured individual. It's usually described in percentages; for example, the insurance company agrees to pay 80 percent of covered charges and the individual pays 20 percent.

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

Coverage: What the health plan does and does not pay for, dependent upon any authorization requirements and the benefit plan.

Covered Expenses: What the insurance company will consider paying for as defined in the member's summary of benefits. For example, under some plans generic prescriptions are covered expenses while brand-name prescriptions are not.

Deductible: A portion of the covered expenses (typically \$100, \$250 or \$500) that an insured individual must pay annually before insurance coverage with co-insurance becomes effective. Deductibles are standard in many indemnity and PPO plans.

Managed Care Plan: A term that typically refers to an HMO, POS, PPO or Exclusive Provider Organization (EPO), but technically means any health plan with specific requirements, like pre-authorization or second opinions, that enables your primary care physician or generalist to coordinate or manage all aspects of your medical care.

Maximum Out-of-Pocket: The most money you can expect to pay for covered expenses. The maximum annual 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, the health plan will pay 100 percent of certain covered expenses.

Open Enrollment: A specified period of time in which employees may change insurance plans and medical groups offered by their employer. The new insurance may be effective the next month or at the beginning of the following year. Open enrollment usually comes once per calendar year.

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

Premium: The money paid to a health plan for coverage. Premiums are usually paid monthly and may be paid in part, or in total, by your employer.

Primary Care Physician (PCP): Under most HMO/POS plans, you'll be asked to name a family practice doctor, pediatrician, obstetrician/gynecologist or an internal medicine physician as your primary care physician. A PCP is responsible for coordinating all of your care. Any specialist referrals you'll need must first be approved by your PCP in order to be considered a covered expense.

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

Specialist: A physician who practices medicine in a specialty area. Cardiologists, pulmonologists and gynecologists are all examples of specialists. Under most health plans, family practice physicians, pediatricians and internal medicine physicians are not specialists. Some health plans (HMO and POS plans) require pre-authorization from your PCP before you can see a specialist.

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. They're also referred to as allowed expenses, and they reflect the provider's retail cost of service. If the fee is greater than an indemnity plan's usual and customary charges, members in these plans are required to pay the difference.