Lesson 1

Health Insurance Glossary

**Coinsurance**
The amount you are required to pay for medical care in certain types of health plans after you have met your deductible. The coinsurance rate is usually expressed as a percentage. For example, if the insurance company pays 80 percent of the claim, you’ll be required to make a 20 percent coinsurance payment.

**Copayment**
A way of sharing medical costs. You pay a flat fee every time you receive a medical service (for example, $20 for every visit to the doctor). The insurance company pays the rest.

**Deductible**
The amount of money you must pay each year to cover your medical care expenses before your insurance policy starts paying.

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

**Health Maintenance Organization (HMO)**
A health insurance plan that allows you to pay a monthly or quarterly premium in exchange for healthcare services. HMOs require you to work with a primary care physician who will direct your care and refer you to specialists as needed. They also require you to see doctors, hospitals, and labs within their network of providers.

**Health Savings Account (HSA)**
A health savings account is a type of medical savings account that allows you to save money to pay for current and future medical expenses on a tax-free basis. In order to be eligible for a health savings account, you must be covered by a high-deductible health plan, not have any other health insurance, and not be claimed as a dependent on another’s tax return.

**Indemnity Plans**
These plans allow you to use any doctor, hospital or specialist you choose and submit a claim to your insurance company for reimbursement of covered medical expenses. Indemnity plans pay a sizable percentage (usually around 80%) of what they consider the “usual and customary” charges and you have to cover the rest.

**Managed care**
The way a healthcare system manages its costs and the use of its resources. All HMOs and PPOs, and even some fee-for-service plans, apply managed care techniques.

**Maximum out-of-pocket**
The maximum amount of money you will be required to pay each year for deductibles, coinsurance and copayments. It is a stated dollar amount set by the insurance company, in addition to regular premiums.

**Point of Service (POS) Plan**
A health insurance plan that combines elements of an HMO and PPO. You can use a primary care physician or self-direct your care at the “point of service.” The cost for services depends on the route you take to get them.

**Preexisting condition**
A health problem that existed before the date your insurance coverage became effective.

**Preferred Provider Organization (PPO)**
A health insurance plan that allows you to see any doctor at any time. In addition to a monthly or quarterly premium, a PPO typically requires you to make a copayment for each service you receive. Copayment for in-network doctors and services are typically lower than copayments for out-of-network doctors and services.
**Premium**
The amount paid by you or your employer, in addition to copayments, coinsurance and deductibles, in exchange for insurance coverage.

**Preventive care**
Services designed to keep patients healthy, including check-ups, well baby care and adult care, immunizations, Pap smears and mammograms.

**Primary care physician**
A primary care physician monitors your health, diagnoses and treats minor health problems, and refers you to specialists if another level of care is needed. This is often a family physician or internist, but some women prefer to use their gynecologist.