IAFF Center of Excellence for Behavioral Health Treatment and Recovery

Glossary of Health Insurance Terms

This glossary defines many commonly used health insurance terms. Terms and definitions may differ from plan to plan.

Allowable charge — sometimes known as the allowed amount, maximum allowable or usual, customary and reasonable (UCR) charge, this is the dollar amount considered by a health insurance company to be a reasonable charge for medical services or supplies based on the rates in your area.

Benefit — the amount payable by the insurance company to a plan member for medical costs.

Benefit level — the maximum amount that a health insurance company has agreed to pay for a covered benefit.

Benefit year — the 12-month period for which health insurance benefits are calculated, not necessarily coinciding with the calendar year. Health insurance companies may update plan benefits and rates at the beginning of the benefit year.

Claim — a request by a plan member, or a plan member's health care provider, for the insurance company to pay for medical services.

Coinsurance — the amount you pay to share the cost of covered services after your deductible has been paid. The coinsurance rate is usually a percentage. For example, if the insurance company pays 80 percent of the claim, you pay 20 percent.

Coordination of benefits — a system used in group health plans 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.

Copayment — one of the ways you share in your medical costs. You pay a flat fee for certain medical expenses (e.g., $10 for every visit to the doctor), while your insurance company pays the rest.

Deductible—the amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying.

Dependent — any individual, either spouse or child, that is covered by the primary insured member's plan.

Drug formulary — a list of prescription medications covered by your plan.

Effective date — the date on which a policyholder's coverage begins.

Exclusion or limitation — any specific situation, condition, or treatment that a health insurance plan does not cover.

Explanation of benefits — the health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.

Group health insurance — a coverage plan offered by an employer or other organization that covers the individuals in that group and their dependents under a single policy.

Health maintenance organization (HMO) — a health care financing and delivery system that provides comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific, in-network plan providers.
Health savings account (HSA) — a personal savings account that allows participants to pay for medical expenses with pre-tax dollars. HSAs are designed to complement a special type of health insurance called an HSA-qualified high-deductible health plan (HDHP). HDHPs typically offer lower monthly premiums than traditional health plans. With an HSA-qualified HDHP, members can take the money they save on premiums and invest it in the HSA to pay for future qualified medical expenses.

In-network provider — a health care professional, hospital, or pharmacy that is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers because they have negotiated a discount for their services in exchange for the insurance company sending more patients their way.

Individual health insurance — health insurance plans purchased by individuals to cover themselves and their families. Different from group plans, which are offered by employers to cover all of their employees.
Medicaid—a health insurance program created in 1965 that provides health benefits to low-income individuals who cannot afford Medicare or other commercial plans. Medicaid is funded by the federal and state governments and managed by the states.

Medicare — the federal health insurance program that provides health benefits to Americans age 65 and older. Signed into law on July 30, 1965, the program was first available to beneficiaries on July 1, 1966 and later expanded to include disabled people under 65 and people with certain medical conditions. Medicare has two parts; Part A, which covers hospital services, and Part B, which covers doctor services.

Medicare supplement plans — plans offered by private insurance companies to help fill the gaps in Medicare coverage.

Network — the group of doctors, hospitals, and other health care providers that insurance companies contract with to provide services at discounted rates. You will generally pay less for services received from providers in your network.

Out-of-network provider — a health care professional, hospital, or pharmacy that is not part of a health plan's network of preferred providers. You will generally pay more for services received from out-of-network providers.

Out-of-pocket maximum — the most money you will pay during a year for coverage. It includes deductibles, copayments, and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Payer — the health insurance company whose plan pays to help cover the cost of your care. Also known as a carrier.

Pre-existing condition — a health problem that has been diagnosed, or for which you have been treated, before buying a health insurance plan.

Preferred provider organization (PPO) — a health insurance plan that offers greater freedom of choice than HMO (health maintenance organization) plans. Members of PPOs are free to receive care from both in-network or out-of-network (non-preferred) providers, but will receive the highest level of benefits when they use providers inside the network.

Premium — the amount you or your employer pays each month in exchange for insurance coverage.

Provider — any person (i.e., doctor, nurse, dentist) or institution (i.e., hospital or clinic) that provides medical care.

Rider — coverage options that enable you to expand your basic insurance plan for an additional premium. A common example is a maternity rider.

Underwriting — the process by which health insurance companies determine whether to extend coverage to an applicant and/or set the policy's premium.

Waiting period — the period of time that an employer makes a new employee wait before he or she becomes eligible for coverage under the company's health plan. Also, the period of time beginning with a policy's effective date during which a health plan may not pay benefits for certain pre-existing conditions.