Health Insurance Plans: Insurance Glossary

Browse our glossary of common health insurance terms and definitions to help you better understand health care and your health insurance plan.

- Authorization (Pre-authorization, Pre-certification)
  An approval from a health plan for a specific covered service, which usually must occur within a certain period. Many health plans, including HMOs, require authorizations for all specialist services, procedures, and inpatient admissions.

- Benefit
  The services that are considered a covered service under an individual's health plan.

- Co-payment
  A set dollar amount for which a patient will be financially responsible when seeking health care services. Co-payments are defined under an individual's benefit design and can vary by the type of provider, visit or service.

- Co-insurance
  The payment percentage for which a patient will be financially responsible when seeking health care services. Co-payments percentage will be based upon the negotiated reimbursement the health plan has in place with the provider. Some Co-Insurance portions may only apply after meeting your deductible.

- Deductible
  The dollar amount a patient is required to pay for covered services before the health plans payment commences. Deductibles are usually accumulated on a calendar year basis but can also be based on the anniversary date of the benefit plan with that plan or plan year of the named insured or subscriber.

- Exclusive Provider Organization (EPO)
  A more restrictive type of Preferred Provider Organization (PPO) plan under which patients must use providers from the specified network of physicians and hospitals for care to be covered by their health plan. Care received from out-of-network providers is usually not covered by the health plan except in emergency situations.

- Guarantor
  The individual or entity who is financially responsible for payment on an account. Usually, the patient is financially responsible for medical charges. A parent or legal guardian/trustee is the guarantor for patients who are 18 years of age and younger. This is also the case for patients with a decreased mental capacity.

- Health Maintenance Organization (HMO)
  A type of health plan that usually limits coverage to care from a limited network of providers who work for or contract with the HMO. HMO's generally do not cover out-of-network services except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

- In-network
  Refers to providers or health care facilities that are part of a health plan's network of providers. Health Plan members usually pay less when accessing an in-network provider, because in-networks provides have negotiated fees for the health plans members covered services.

- Inpatient (IP)
- patient who has been admitted to a hospital and or facility and their physician has ordered an "inpatient admission".

- Medi-Cal
  A California state sponsored medical assistance program enabling eligible recipients to obtain essential medical care and services.

- Medicare (Part A &B)
  Medicare is a federal insurance program which primarily serves those over 65 years old and younger, disabled people and dialysis patients. Medicare is divided into two parts for hospital and provider care benefits:
    - Medicare Part A covers inpatient hospital services, nursing home care, home health care and hospice care.
    - Medicare Part B helps pay the cost of doctors' services, outpatient hospital services, medical equipment and supplies and other health services and supplies.
    - Medicare Advantage (Medicare Part C)
      - A type of Medicare health plan offered by a private company that contracts with Medicare to provide its members with all their Part A and Part B benefits.

    - Medicare Advantage Plans include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) , Private Fee-for-Service Plans (PFFS), Special Needs Plans (SNP), and Medicare Medical Savings Account Plans (MSA).
      - If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the Medicare Advantage Plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.
    - Medicare Part D
      - A program that helps pay for prescription drugs for individuals with Medicare who join a health plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage:
      - Through a Medicare Prescription Drug Plan or Medicare Advantage Plan that includes drug coverage. These options are offered by health plans and other private companies approved by Medicare.

- Medicare Supplement
  A supplemental private insurance policy to help cover the difference between approved medical charges and benefits paid by Medicare.

- Non-Covered Services
  A service provided to a patient that is not considered a covered service under the individual's benefit plan. Health Plans do not make payment to providers for non-covered services and the patient will be financially responsible for the cost of the services provided.

- Out-of-Network
  Services rendered by a provider who is not a part of the health plans contracted network of providers. If an individual seeks care out-of-network, they may be financially responsible for some or all of the care provided. An exception to this rule is emergency medical care.

- Out-of-Pocket Costs
  The amount that is paid by the patient or guarantor for covered services.

- Out-of-Pocket Maximum
  The maximum dollar amount that is paid by the patient or guarantor on an annual basis.

- Outpatient
  A treatment or service an individual receives that does not require an inpatient hospitalization.

- Preferred Provider Organization (PPO)
  A health plan that contracts with a network of providers, such as hospitals and physicians, to create a network of participating providers. Individuals will have defined financial responsibility if they access an in- network provider. You pay less if you use providers that belong to the health plan's network. Some PPO health plans may allow an individual to access covered services from out-of-network providers, but such services would be at a reduced benefit level and at a higher cost You can use doctors, hospitals, and providers outside of the network for an additional cost.

- Primary Care Physician (PCP)
  A physician (Provider, Doctor) who provides or coordinates a range of health care covered services for a patient.

- Most HMO, EPO and POS plans require that members choose or be assigned to a PCP.
  The PCP is responsible for providing or referring all care (hospitalization, diagnostic and specialty referrals) for PCPs assigned members. Depending on the type of health plan and the individuals benefit plan, specialist or other providers' services may not be a covered service without a referral from the patient's PCP.

- Provider
  A hospital, physician, laboratory, imaging, or other type of health care entity who provides medical services.

- Referral
  An order from your PCP which allows a patient to see a specialist or other type of provider receive certain covered services. The referral may limit the type of services which are to be made available and the time restriction in which the services must be provided. In many Health Maintenance Organizations (HMOs), a referral is required prior to receiving medical care from any providers who are not the individual's PCP. Not assuring a referral is in place for the covered services may cause the health plan to deny payment and the patient may be held financially responsible for the services provided. If you do not receive a referral first, the plan may not pay for the services.

- Specialist
  A physician that focuses on a specific area of medical practice or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.