Healthy Capital District
Get Covered • Find Care • Stay Healthy

Guide to Insurance Terms

Access: The availability of medical care. The quality of one's access to medical care is determined by location, transportation options, and the type of medical care facilities available in the area, etc.

Ancillary Fee: An extra fee sometimes associated with obtaining prescription drugs which are not listed on a health insurance plan's formulary of covered medications.

Balance Billing: The amount you could be responsible for (in addition to any co-payments, deductibles or coinsurance) if you use an out-of-network provider and the fee for a particular service exceeds the allowable charge for that service.

Benefit: A general term referring to any service (such as an office visit, laboratory test, surgical procedure, etc.) or supply (such as prescription drugs, durable medical equipment, etc.) covered by a health insurance plan in the normal course of a patient's healthcare.

Cost-sharing: Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include deductibles, coinsurance, and co-payments. Balance-billed charges from out-of-pocket physicians are not considered cost-sharing.

Coinsurance: The amount that you are obliged to pay for covered medical services after you've satisfied any co-payment or deductible required by your health insurance plan. Coinsurance is typically expressed as a percentage of the charge or allowable charge for a service rendered by a healthcare provider. For example, if your insurance company covers 80% of the allowable charge for a specific service, you may be required to cover the remaining 20% as coinsurance

Co-payment: A specific charge that your health insurance plan may require that you pay for a specific medical service or supply, also referred to as a "co-pay." For example, your Medicaid plan may require a $3.00 co-payment for a clinic visit, after which the insurance company would pay the remainder of the charges.

Deductible: A specific dollar amount that your health insurance company may require that you pay out-of-pocket each year before your health insurance plan begins to make payments for claims. Not all health insurance plans require a deductible. As a general rule (though there are many exceptions), HMO plans typically do not require a deductible, while most Indemnity and PPO plans do.

Effective Date: The date on which health insurance coverage comes into effect.

Eligibility Date: The date on which a person becomes eligible for insurance benefits.

Generic Drug: A drug which is exactly the same as a brand name prescription drug, but which can be produced by other manufacturers after the brand name drug's patent has expired. Generic drugs are usually less expensive than brand name drugs.

Grace Period: A time period after the payment due date, during which insurance coverage remains in force and the policyholder may make a payment without penalty.

In-area Services: Healthcare services rendered within a health insurance plan's coverage are

Lapse: The termination of insurance coverage due to lack of payment after a specific period of time

Maximum Out Of Pocket Costs: An annual limitation on all cost-sharing for which patients are responsible under a health insurance plan. For example, a standard maximum-out-of-pocket cost for a Medicaid recipient is $200.00.

Network: A "Network" plan is a variation on a PPO plan. With a Network plan, you'll need to get your medical care from doctors or hospitals in the insurance company's network if you want your claims paid at the highest level. You will probably not be required to coordinate your care through a single primary care physician, as you would with an HMO, but it's up to you to make sure that the health care providers you visit participate in the network. Services rendered by out of network providers may not be covered or may be paid at a lower level.

Out-of-network Care: Healthcare rendered to a patient outside of the health insurance company's network of preferred providers. In many cases, the health insurance company will not pay for these services.

Preventive Care: Medical care rendered not for a specific complaint but focused on prevention and early detection of disease. This type of care is best exemplified by routine examinations and immunizations. Some health insurance plans limit coverage for preventive care services, while others encourage such services. Note that well-baby care, immunizations, periodic prostate exams, pap smears and mammograms, though considered preventive care, may be covered even if your health insurance plan limits coverage for other preventive care services.

Utilization: This term refers to how frequently a group uses the benefits associated with a particular health insurance plan or healthcare program.

Reference:

Health Insurance Glossary. (2017). Retrieved from http://www.ehealthinsurance.com/health-insurance-glossary/terms-w/