Understanding Health Insurance Terms

Covered benefits
Types of medical or mental health services your insurance company will pay for.

Co-insurance amount
This is the percentage of your medical expenses you must pay after you reach your deductible. This will typically range from 20 percent to 50 percent.

Co-payment
A way of sharing insurance costs with your insurance company. You pay a flat fee every time you receive a covered service (for example, $20 for every visit).

Covered Services
Most health insurance plans do not pay for all services. For example, some may not pay for mental health care. Others may not pay for testing for certain diagnoses (i.e., learning disabilities, ADHD). Covered services are those medical procedures the insurer agrees to pay for. They should be listed in the health insurance policy.

Deductible
The amount of money you must pay each year to cover your medical/mental health care expenses before your health insurance policy begins to pay for services.

Exclusions
The specific diagnoses or conditions or circumstances for which the policy will not provide benefits.

Maximum Out-of-Pocket Expenses
This is a maximum amount you are required to pay “up front” in a given year, after which the insurer will pay 100 percent toward the cost of covered medical expenses. At the end of each insurance year, the amount the you have paid toward the maximum goes back to “zero”.

Out-of-Network Benefits
Benefits in your insurance plan that allows you to receive services from a provider that is not in your insurance company’s Preferred Provider Network (PPO). Out-of-network benefits usually require you to pay a higher percentage of the cost of services (for example, 50% instead of 20%) and/or require a larger deductible (for example, $500 instead of $250).

PPO (Preferred Provider Organization)
A combination of traditional fee-for-service and an HMO. When you use the doctors and hospitals that are part of the PPO, you can have a larger part of your medical/mental health bills covered. With some PPO policies, you can use other providers, but at a higher cost.

Pre-Authorization
A cost containment feature of many policies in which the owner of the policy must contact the insurance company prior to testing or treatment and receive authorization for the service being sought.

Pre-existing Condition
A health problem that existed before the date your health insurance became effective.

Third-Party Payer
Any payer for health care services other than you. This can be an insurance company, an HMO, a PPO, or the Federal Government.