Healthcare Words to Know

Agent/Broker: The person who sells you an insurance plan. Your contact person at the insurance company.

Appeal: An action you can take if you believe you were wrongly denied care or coverage. An appeal asks your insurance provider to review a decision they made.

You can appeal if your plan denies:

- coverage for a healthcare service, supply, or prescription drug you think should be covered
- payment for healthcare or a prescription drug you already got
- your request to change the amount you must pay for a prescription drug

You can also appeal if you are getting coverage and your insurance plan stops paying.

Beneficiary: The people who receive benefits under health insurance. You are the beneficiary of your plan because you receive services. Your family members are also beneficiaries if the plan covers your family.

Co-insurance: Your share of the costs of a covered service. Co-insurance begins after you pay your deductible. Co-insurance is a percent. It is not a fixed amount. You will pay more for services that cost more. You will pay less for services that cost less.

Co-pay: A fixed amount of money you pay at the time you receive certain medical service. It is a separate cost from your premium payment.

Deductible: An amount you pay for certain services before your insurance starts to pay. The amount must be paid in total before insurance pays. Your insurance pays for most healthcare costs that year after you pay your deductible.

Excluded services: Healthcare services your health coverage or plan does not pay for.

Explanation of Benefits (EOB): Shows the total charges after you see a provider or get a service. It is a record of the healthcare you or your family got. It shows how much your provider is charging the insurance plan. It shows how much you and your health plan will pay. It is not a bill.

Formulary: A list of prescription drugs covered by a health insurance plan. Also called a drug list.

Health Maintenance Organization (HMO): A type of health insurance plan. It usually only covers care from doctors who work for or contract with the HMO. An HMO usually pays for care only within its network.

Managed Care Plans: A type of plan. The plan contracts with healthcare providers and facilities to provide care at reduced costs. These providers make up the plan's net work. The amount of care these plans pay for depends on the network's rules.

Network: The group of doctors and providers your health insurance company works with It costs you less when you see a provider in your network. You may have a doctor you like. Be sure to pick a health plan that has your doctor in its network. Also known as in-network.

Out-of-network: It describes a provider who does not have a contract with your plan to provide services. You will pay more to use them.

Out-of-pocket maximum: The most you will pay during a plan period before your plan pays 100%. A plan period is usually a year. This includes co-pays, deductibles and co-insurance. These are called out-of-pocket costs or cost sharing.

Point of Service (POS) Plan: A type of plan. It lets you choose between a PPO or HMO each time you need care. You pick a primary care doctor from a list of network providers. Your care is managed by this doctor. The doctor is your point of service (POS). They will refer you to other in-network providers when needed.

Preferred Provider Organization (PPO): A type of plan. It contracts with medical providers to create a network. The network includes providers like hospitals and doctors. You pay less if you use providers in the plan's network. A PPO will pay part of your healthcare costs if you go outside the network. You will have to pay more for care outside of the network.

Premium: A fixed amount of money you must pay monthly for your health insurance.