Glossary of Key Insurance Terms

**Coinsurance** – The amount or percentage that you pay for certain covered health care services under

your health plan. This is typically the amount paid after a deductible is met, and can vary based on the

plan design.

**Copayment** – The flat fee that you pay towards the cost of covered medical services.

**Covered Expenses** – Health care expenses that are covered under your health plan.

**Deductible** – A set dollar amount that a person must pay before insurance coverage for medical

expenses can begin. They are usually charged on an annual basis.

**In‐Network** – Refers to physicians, hospitals or other health care providers who contract with the

insurance plan to provide services to its members. Coverage for services received from in‐network

providers will typically be greater than for services received from out‐of‐network providers.

**Inpatient** – A person who is treated as a registered patient in a hospital or other health care facility. This person accrues room and board charges.

**Maximum Benefit** – The maximum dollar amount that an insurance company will pay for claims, either for a specific service or procedure, or during a specified period of time.

**Medically Necessary (or medical necessity)** – A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.

**Out‐of‐Network** – Refers to physicians, hospitals or other health care providers who do not contract

with the insurance plan to provide services to its members. Depending upon the insurance plan,

expenses incurred for services provided by out‐of‐network providers might not be covered, or coverage

may be less than for in‐network providers.

**Out‐of‐Pocket Expense** – Amount that you must pay towards the cost of health care services. This

includes deductibles, copayments and coinsurance.

**Preferred Provider Organization (PPO)** – A health plan that offers both in‐network and out‐of‐network benefits. Members must choose one of the in‐network providers or facilities to receive the highest level of benefits.

**Premium:** The amount you pay for your health insurance plan on an annual or monthly basis.

**Primary Care Physician (PCP)** – The doctor that you select to coordinate your care under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

**Usual, Customary and Reasonable (UCR) Allowance** – The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges then are the responsibility of the patient.