Healthcare Terminology

Healthcare Network Types

The two most common types of healthcare networks are health maintenance organizations and preferred provider organizations.

Health Maintenance Organization (HMO) plans feature low costs (i.e., premiums and deductibles), but restricts frequency of receiving services and contains the services to specific providers within the network. Members may be required to choose a primary care physician, who coordinates care and refers you to specialists within the network.

Preferred Provider Organization (PPO) plans are more flexible in terms of services out-of-network. Although at a higher cost, out-of-network services are still accessible and specialists can be seen without a referral. This flexibility costs more in premiums and deductibles than HMOs.

Terminology: Healthcare Insurance Plans

Allowed Amount is the highest amount the insurance company will pay for a service.

Copay is the amount you pay to a healthcare provider at the time you receive services. Not all plans have a copay.

Coinsurance is a certain percent you must pay after you have paid your deductible. This payment is for covered services only. You still may have to pay a copay.

Covered Charges are charges for covered services that your health plan pays for.

Deductible is what you are required to pay annually out-of-pocket up to a certain amount before the insurance company begins to pay on a health insurance claim.

High-Deductible Health Plans (HDHPs) have high deductibles and are unique in that payments towards deductibles and other costs can be paid with pre-tax dollars via a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). Lower premiums are also featured in HDHPs.

Medical Services are services related to diagnosing, monitoring or treating health conditions.

Premium is the amount that an individual and/or their employer pays for a health insurance plan. It is usually paid month, quarterly, or yearly.

Preventative Services are received before you have any related health condition or problem.

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Other Key Terminology

Flexible Spending Account (FSA), is a tax-exempt account that's used to pay for eligible medical, dental, and vision care expenses that are not covered by your health care plan or elsewhere. Employees pay into their FSA; employers may make contributions but are not required to.

Health Savings Account (HSA), is a tax-exempt savings account that, when paired with a qualified high-deductible health plan (QHDHP), can be used to pay for certain medical expenses. Funds deposited are not taxed, nor are withdrawals for qualified expenses.

Voluntary Benefits, or supplemental insurance, are designed to provide additional cash flow to assist with out of pocket medical costs and other bills based on individual concerns and needs. They are offered through an employer but paid for partially or solely by workers (e.g., life, disability, critical-illness, accident insurances, ID theft protection).

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