Some Terms Used in Health Insurance Plans

HMO: a plan which directs participants to one group of clinics and doctors; there is little or no coverage outside of this group.

PPO: a plan which has increased benefits within a group or network of doctors and clinics. There is reduced coverage, higher deductibles, and higher or no co-pays outside of the network.

Fee for Service: a plan which allows participants to choose freely among doctors and clinics. Some of these plans use re-imbursement only..

Lifetime payout: The amount an insurance company will pay out for medical care and treatments throughout an insured's lifetime.

Rider: an amendment to a health plan which restricts or eliminates coverage for a particular ailment. This may be permanent or have an option to be reviewed. Sometimes referred to as a waiver.

Co-pay: nominal fee paid at time of office visit or treatment. Remaining cost paid at 100% by the company.

Co-insurance: Portion of coverage shared by insured and insuring company. For example, 80/20 to $5000 means that the company will pay 80% of $5000 and the insured pays 20% or $1000. The co-insurance is usually capped.

Out of Pocket: Refers to the maximum amount the insured would pay under a plan. In the example above, the $1000 would be the maximum to be paid out of pocket in addition to the deductible.

Deductible: An amount, usually at the insured's option, which the insured pays prior to any payment by the company. Generally between $250 and $5000. Sometimes referred to as self-insurance amount.

Rating: A scoring given to a companyby an outside firm which specializes in reviewing the financial standings of companies. Some of these which rate insurance companies are A.M. Best, Standard & Poor, and Moody's.

Exclusions: Treatments, diseases, and incidents which are not covered by the plan.