WHAT IS HEALTH INSURANCE?

Health insurance is when you pay an insurance company a certain amount of money each month for an insurance plan and a certain amount of money each time you receive health care. In exchange, the insurance company pays your health care providers (e.g. your therapist, psychiatrist, etc.) for the services they provide. In real life, it’s more complicated than that. For example, some insurance companies will only sell plans that cover certain services or will only pay a certain portion of the cost for some services. Here are some health insurance terms to help you understand how it works.

10 Basic Health Insurance Terms

1. **Claim**: The bill you or your doctor or health care provider submits to your health insurance company.

2. **Co-pay (out-of-pocket cost)**: A co-payment, or co-pay, is the amount the insured person pays every time he or she receives a health service. For instance, if your co-pay to see a doctor is $25, you pay that amount each time you see him or her. The insurance takes care of the rest.

3. **Co-insurance (out-of-pocket cost)**: Your part of the costs of a health service that is covered by insurance. It is calculated as a percentage and you pay it in addition to whatever deductible you may owe. For example if your plan allows $100 for a doctor visit and you’ve already met your deductible, your co-insurance payment of 20% would be $20. The insurance plan picks up the rest of the cost.

4. **Deductible (out-of-pocket cost)**: The amount you owe before your health insurance benefits kick in. For example, if your deductible is $500, your insurance won’t pay for anything until your costs are more than $500.

5. **Dependent**: An individual—usually a child or a spouse—who relies on another person for support and who obtains health coverage through that person (usually a spouse or parent).

6. **In- and out-of-network**: An in-network provider is a health care office that has contracted with the health insurance company to provide services for people on that insurance plan. An out-of-network provider is someone who does not have such a relationship with the insurance company. Typically, insurance will only cover the cost of services from health care providers who are “in-network.”

7. **Out-of-pocket maximum**: The most you pay during the period of your policy (most policies go for a year) before your insurance plan begins to pay 100% of the allowed amount. This total does not include your balance-billed charges, your premium, or the health care services your plan doesn’t cover. Some plans don’t count the out-of-network payments, co-insurance payments, co-payments, other expenses or deductibles toward this amount, so read the plan instructions carefully.

8. **Premiums**: The amount you must pay each month for your insurance plan.

9. **Preventive care**: Routine health care that includes regular checkups, patient counseling and screenings to prevent disease, illness and other health complications.

10. **Providers**: A health professional that provides health services to people (doctors, nurses, therapists, physician’s assistants, etc.)

Want to see how much you learned? Quiz yourself [here](#)!
ADDITIONAL HEALTH INSURANCE VOCABULARY

1) **Fee-for-service**: The traditional health care payment system (also known as indemnity insurance) under which providers receive a payment that does not exceed their billed charge for each unit of service provided. Under a fee-for-service insurance plan, people can usually choose any provider they want, as long as the provider is willing to accept the insurance company’s payments.

2) **Health maintenance organization (HMO)**: A health care financing and delivery system that provides comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific plan providers.

3) **Managed Care**: Generally a health care delivery system that links doctors, hospitals and an insurance plan to deliver care to the plan’s members with the intent of improving quality and reducing costs. Health insurance can manage care in a number of ways, including requiring members to choose a primary care provider, to obtain the primary care provider’s permission to see a specialist and to use only providers with the plan’s network of providers.

4) **Medicare**: A federal health insurance program for people age 65 and older and some younger disabled people. In original Medicare, a fee-for-service program, you can go to any doctor or hospital that participates in Medicare. Medicare will pay the doctor or hospital directly for eligible services they provide.

5) **Medicaid** is the joint federal/state health insurance program to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers and pregnant women who meet the program’s financial requirements. Each state has a Medicaid program. Wisconsin Medicaid is also known as the Medical Assistance (MA) Program, Title XIX, or T19. In Wisconsin, we have several types of Medicaid coverage. For an overview, check out the NAMI WI overview of “Mental Health Financing.”

6) **Medically necessary**: Services or supplies that meet the following: (1) they are appropriate and necessary for symptoms, diagnosis, or treatment of the medical condition; (2) they are provided for the diagnosis or direct care and treatment of medical conditions; (3) they meet the standards of good medical practice within the medical community in the service area; (4) they are primarily for the convenience of the patient or provider; (5) they are the most appropriate level or supply of service that can safely be provided.

7) **Primary care provider**: The first health care provider a managed care plan’s member is required to contact when he or she needs health care services, usually a physician specializing in primary care services. The primary care provider is responsible for knowing the member’s complete medical history, performing routine health care duties, and referring the member to a specialist when necessary.

8) **Preauthorization/precertification**: A provision in insurance policies that requires prior approval by a managed care plan or limited service health organization in order for services to be covered by the plan.

9) **Allowed amount**: This may also be called an “eligible expense” or “negotiated rate” or “payment allowance.” It is the maximum amount on which payment is based for health care services that are covered by your insurance.*A comprehensive glossary can be found on the WI Office of the Commissioner of Insurance website, available here.

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