A Glossary of Health Care and Health Insurance Terms

Understanding health care and health insurance can feel overwhelming, especially when you are faced with unfamiliar acronyms, industry jargon, and complex benefit details. Whether you are reviewing your health plan, comparing coverage options, or trying to understand a medical bill, knowing the basic terminology can help you make more informed decisions and avoid unnecessary confusion.

This glossary provides plain-language definitions of common health care and health insurance terms you may encounter when receiving care, evaluating benefits, or exploring coverage options for yourself, your family, or your employees.

Care, Coverage, and Billing Terms

Co-insurance: Co-insurance is the percentage of covered medical costs you pay after you've met your deductible. For example, if your plan has a 20% co-insurance requirement, your insurance company pays 80% of covered expenses and you pay the remaining 20%.

Co-payment (Copay): A copayment is a fixed dollar amount you pay for a specific health care service, such as $25 for a primary care visit or $50 for a specialist appointment.

Deductible: Your deductible is the amount you must pay out of pocket for covered health care services before your insurance plan begins sharing costs. Most plans have individual and family deductibles that reset annually.

In-Network: In-network providers are doctors, hospitals, clinics, and other health care professionals that have contracted with your insurance company. Using in-network providers typically results in lower out-of-pocket costs.

Out-of-Network: Out-of-network providers do not have agreements with your insurance carrier. While some health plans offer out-of-network coverage, members generally pay a larger share of the costs when using these providers.

Out-of-Pocket Maximum: Also called an out-of-pocket limit, this is the most you'll pay during a plan year for covered medical services through deductibles, copayments, and co-insurance. Once you reach this limit, your health plan typically pays 100% of the services covered for the remainder of the year.

Premium: A premium is the amount paid for health insurance coverage. Premiums are often paid monthly and may be paid by an individual, an employer, or shared between both.

General Health Insurance Terms

COBRA (Consolidated Omnibus Budget Reconciliation Act): COBRA is a federal law that allows individuals to continue their employer-sponsored health insurance for a limited period after leaving a job or experiencing certain qualifying events. Participants generally pay the full cost of coverage.

Formulary: A formulary is a health plan's list of covered prescription drugs. Medications are often organized into tiers, with lower-cost generic drugs receiving greater coverage than brand-name or specialty medications.

Marketplace: The Health Insurance Marketplace is a service that helps individuals and families compare and enroll in health insurance plans. Most consumers use HealthCare.gov, while some states operate their own marketplaces.

Primary Care Physician (PCP): A Primary Care Physician is your main health care provider who delivers routine care, diagnoses common conditions, coordinates treatment, and refers patients to specialists when necessary.

HMO (Health Maintenance Organization): An HMO is a health insurance plan that requires members to use a specific provider network. Members typically choose a PCP and obtain referrals before seeing specialists. HMOs often offer lower out-of-pocket costs in exchange for less flexibility.

PPO (Preferred Provider Organization): A PPO allows members to use both in-network and out-of-network providers without referrals. While PPOs provide greater flexibility, members usually pay less when receiving care within the plan's preferred network.

Summary of Benefits and Coverage (SBC): The SBC is a standardized document required by the Affordable Care Act that outlines a health plan's benefits, costs, coverage limitations, and examples of common medical expenses. It makes it easier to compare plans side-by-side.

FSA (Flexible Spending Account): An FSA is an employer-sponsored account that allows employees to set aside pre-tax money for eligible medical, dental, vision, and dependent care expenses. FSAs can reduce taxable income, but unused funds may be forfeited at the end of the plan year.

HRA (Health Reimbursement Arrangement): An HRA is an employer-funded benefit that reimburses employees for qualified medical expenses and, in some cases, health insurance premiums. Employers determine contribution amounts and reimbursement rules.

HRA (Health Savings Account): An HSA is a tax-advantaged savings account designed for individuals enrolled in a qualifying High-Deductible Health Plan (HDHP). Contributions, investment growth, and withdrawals for qualified medical expenses are generally tax-free.

The Bottom Line

Health insurance decisions become much easier when you understand the terminology behind the coverage. From deductibles and copays to ICHRAs, HSAs, and self-funded plans, knowing these common definitions can help you better evaluate your options, understand your costs, and make confident health care decisions for yourself, your family, or your employees. Taking time to learn the language of health insurance is one of the best ways to maximize the value of your benefits and avoid surprises when care is needed.

Start the Conversation

Speak to a licensed Gallagher broker today to go over all your options and find out what plans work best for you or your family. IBPSA Members can contact a dedicated agent today by calling **844-863-9553** or by visiting **https://ahs-member-us.ajg.com/ibpsahealth**

Gallagher

Insurance | Risk Management | Consulting