

# Medical Terminology

**Allowed Charges:** The maximum amount, according to the individual policy, that the insurance will pay for each procedure or service performed.

**Co-payment:** Also known as co-insurance. The co-payment is the portion the patient pays when his other policy does not cover 100%. The amount is pre-established by the policy and is due at the time of the office visit.

**Deductible:** Amounts payable by the policyholder before the insurance company is obligated to pay benefits. Pre-selected at the time of policy purchase.

**Dependent:** A person financially supported by the policyholder; meets the legal requirement for inclusion in a policy.

**Exclusion:** Any condition or expense for which, under the terms of the insurance policy, no coverage is provided and no payment will be made.

**HMO (Health Maintenance Organization):** HMO's are the oldest form of managed care plan. In an HMO, instead of paying for each service that you receive separately, your coverage is paid in advance. This is called prepaid care. For a set monthly fee, HMO's offer members a range of health benefits, including preventive care. HMO's will give you a list of doctors from which to choose a primary care physician. This doctor coordinates your care, which means that generally you must contact him or her to be referred to a specialist. Typically, with most HMO's there is a co-payment for offices visits, hospitalizations, and other health services.

**Medicaid:** Medicaid is a jointly-funded, Federal-State health insurance program for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments.

**Medicare:** The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

**Preferred Provider Organization (PPO):** A PPO is a form of managed care closest to an indemnity plan. A PPO negotiates arrangements with doctors, hospitals, and other providers of care who accept lower fees from the insurer for their services. As a result, your cost sharing will be lower than if you go outside the network of providers. If you go to a doctor within the PPO network you will pay a set amount co-payment. Another characteristic of PPO's is the ability to make self-referrals. In essence, plan members can refer themselves to doctors of their choice, including specialists inside and outside the network.