Understanding Health Insurance Terms

- **Advance Premium Tax Credit** – A new tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit to apply to your premiums each month, up to a maximum amount. If your advance payments for the year are less than the credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments are more than the amount of your credit, you must repay the excess with your tax return. Also called premium tax credit.
- **Affordable Care Act (ACA)** – The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.
- **Ambulatory Care** – Health care services that do not require a hospital stay, such as those provided in a doctor's office, clinic or day surgery center.
- **Benefits** – The amount of money payable by an insurance company to a claimant under the insurance policy.
- **Brand-name Drugs** – Prescription drugs sold by a drug company under a specific name or trademark and protected by a patent. Brand-name drugs may be available by prescription or over the counter.
- **Capitation** – A set dollar limit that a health maintenance organization (HMO) pays to your primary care physician for providing medical treatment to you and your dependents. The fee is usually paid to the physician on a monthly basis. The physician gets no more or less than this set fee, no matter how much or how little you use his or her services.
- **Case Management** – A technique that insurance companies and HMOs use to ensure that individuals receive appropriate, timely and reasonable health care services.
- **Children's Health Insurance Program (CHIP)** – A government insurance program jointly funded by state and federal government that provides health coverage to low-income children and, in some states, pregnant women in families that earn too much income to qualify for Medicaid but can't afford to purchase private health insurance coverage.
- **Claim** – A request by an individual (or his or her provider) for the insurance company to pay for services obtained.
- **Coinsurance** – The money that an individual is required to pay for services after the deductible has been met. It is often a specified percentage of the charges. For example, the employee pays 20 percent of the charges while the health plan pays 80 percent.
- **Consolidated Omnibus Budget Reconciliation Act (COBRA)** – A federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event.
- **Copayment** – An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered. Copayments are usually a set dollar amount (such as $20 per office visit), rather than a percentage of the charges.
- **Deductible** – A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual basis.
- **Denial of claim** – Refusal by an insurance company to pay a submitted request for health care services obtained.
- **Dependent** – Any individual, adult or minor whom a parent, relative or other person may choose to cover on his or her insurance plan.
- **Essential Health Benefits** – A set of health care service categories that must be covered by certain plans.
- **Exclusions and Limitations** – Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).
- **Exclusive Provider Organization (EPO)** – Health care plans similar to preferred provider organizations (PPOs), with the main difference being that services are covered only if you go to doctors, specialists or hospitals in the plan's network, although there are exceptions for emergencies.
- **Generic Drugs** – A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand- name drugs.
- **Group Health Plan** – A health plan offered by an employer or employee organization that provides health coverage to a large group of people at a discounted rate.
- **Health Insurance** – A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.
- **Health Insurance Marketplace (Marketplace)** – A state or federal resource where individuals, families, and small businesses can shop for health insurance plans based on costs, benefits and other important features, and enroll in coverage. Individuals who enroll in a health insurance plan through the Marketplace may be eligible for Advance Premium Tax Credits and other assistance in paying for coverage. Also known as Exchanges.
- **Health Maintenance Organization (HMO)** – Prepaid, or capitated, health care plans in which individuals pay a small monthly fee to be a member of the HMO, as well as small fees or copayments for specified health care services. Services are provided by physicians and allied health care personnel who are employed by or under contract with the HMO. HMOs

are available to both individuals and employer groups.

- **High Deductible Health Plan (HDHP)** – A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with an HSA or an HRA to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.
- **In-network** –Typically refers to physicians, hospitals or other health care providers who contract with an insurance plan (usually an HMO or PPO) to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.
- **Medicaid** – A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and, in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their programs, so Medicaid varies state by state and may have a different name in your state.
- **Medically Necessary** – A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.
- **Medicare** – A federal health insurance program for people who are age 65 or older and for certain younger people with disabilities. It also covers people with End-stage Renal Disease (ERSD)—permanent kidney failure requiring dialysis or a transplant.
- **Medicare Part D** – A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.
- **Open Enrollment Perio**d – A period of time, usually but not always occurring once per year, when employees of companies and organizations may make changes to their health insurance and other benefit options. The term also applies to the annual period in which individuals may buy health insurance plans through the Marketplace.
- **Out-of-network** – Typically refers to physicians, hospitals or other health care providers who do not contract with an insurance plan to provide services to its members. Depending on the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.
- **Out-of-pocket Maximum (OOPM)** – The total amount paid each year by the member for the deductible, coinsurance, copayments and other health care expenses, excluding the premium. After reaching the out-of-pocket maximum, the plan pays 100 percent of the allowable charges for covered services the rest of that calendar year.
- **Point-of-service Plan (POS)** – A type of HMO that allows the patient to see either in- network or out-of-network providers. However, the patient pays more out of pocket when using an out-of-network provider.
- **Pre-admission Certification** –Approval granted by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or inpatient facility before admittance. The goal is to ensure that individuals are not exposed to inappropriate health care services, or services that are not medically necessary. Also called “precertification” or “pre-admission review.”
- **Premium** – The amount of money charged by an insurance company for coverage.
- **Preventive Care** – Any medical checkup, test, immunization, or counseling service used to prevent chronic illnesses from occurring.
- **Primary Care Physician (PCP)** – A health care professional who is responsible for monitoring an individual’s overall health care needs. Typically, a PCP serves as a gatekeeper for an individual’s medical care, referring him or her to specialists and admitting him or her to hospitals when needed.
- **Qualified Medical Expense** – The costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Self-insured** – A health benefits plan in which the employer is responsible for the cost of its employees’ health care. Typically, a third party provides administrative services for the plan to the employer group.
- **Summary of Benefits and Coverage (SBC)** – An outline of a health insurance plan that allows somebody to evaluate costs and coverage and compare against other health plans.
- **Wellness Program** – A program intended to improve and promote health and fitness, usually offered through the workplace, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs and preventive health screenings.