Know Your Benefits

Health Insurance Terms You Need To Know

The health care system in the United States can be confusing. In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, the government, health plans and health care providers. This way, you can make better decisions and ultimately receive better care.

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.

Annual Limit – A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. These caps are sometimes placed on particular services, such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Assignment of Benefits – A document you sign that allows your hospital or doctor to collect your health insurance benefits directly from your health carrier. Otherwise, you pay for treatment and the insurance company reimburses you.

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.

Broker – An independent insurance agent who works with many insurance companies to find insurance policies for his or her clients.

Cafeteria Plans – Benefit programs that help employees pay for certain expenses, such as life insurance, disability benefits, medical expenses and child care, with pre-tax dollars. Employers select the benefits that will be offered (only certain benefits can be provided), and employees use pre-tax dollars to buy the benefits they want. Employers can also make contributions to subsidize benefits. Cafeteria plans are also known as flexible benefit plans or IRS 125 Plans.

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.

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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% of the charges while the health plan pays 80%.

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.

Dental Insurance – Insurance that helps pay for dental care and usually includes regular checkups, cleanings, X-rays and certain services required to promote general dental health. Some plans will provide broader coverage than others, and some will require a greater financial contribution from you when services are rendered. Some plans may also provide coverage for certain types of oral surgery, dental implants or orthodontia.

Dependent – Any individual, adult or minor whom a parent, relative or other person may choose to cover on his or her insurance plan.

Employee Assistance Program (EAP) – Mental health counseling services that are sometimes offered by insurance companies or employers. Typically, individuals or employers do not have to pay directly for EAP services provided.

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.

Fee-for-service Plans (FFS) – A type of coverage where insurers pay for health care services provided to plan participants. With this type of coverage, you can choose any doctor you wish and change doctors any time or go to any hospital in any part of the country. These plans existed primarily before the rise of HMOs and PPOs.

Flexible Spending Account (FSA) – An individual arrangement set up through employers to pay for many of out-of-pocket medical expenses with tax-free dollars. The FSA account holder sets aside a pre-tax dollar amount for the year which he or she can use to pay medical expenses. Unused FSA funds can expire, depending on the policy of the account holder's employer.

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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.

Grandfathered Health Plan – A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010, and is exempt from many, but not all, provisions of the ACA.

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.

Health Reimbursement Arrangement (HRA) – Employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses. Like health savings accounts (HSAs), unused amounts may be rolled over to be used in subsequent years. Unlike HSAs, the employer funds and owns HRA accounts. The employer sets up the HRA, determines the amount of money available in each employee's HRA for the coverage period and establishes the types of expenses the funds can be used for.

Health Savings Account (HSA) – A medical savings account available to people who are enrolled in an HSA-compliant high-deductible health plan. The account is employee-owned, and money may be contributed by both the employer and employee. If the employee leaves the company, he or she remains in control of the account. The funds contributed to the account are pre-tax, which means they aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses; there is a heavy tax penalty for using HSA funds for non-qualified expenses. Funds roll over year to year if you don't spend them, and can accumulate a significant balance. There is a limit to how much money can be put into an HSA every year, but no cap on how much money can be in the account.

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.

Independent Practice Association (IPA) – A group of independent practicing physicians who band together for the purpose of contracting with HMOs, PPOs and insurance companies for their services.

Individual Mandate – The ACA requirement that most individuals obtain acceptable health insurance coverage for themselves and their family members or pay a penalty. There is a graduated tax penalty, or fee, for individuals who do not obtain health insurance by the time they file their taxes for 2014. **Note:** Effective for plan years beginning Jan. 1, 2019, the individual mandate is no longer applicable. However, a few states (including Massachusetts, New Jersey, Vermont, California, Rhode Island and the District of Columbia) have created their own individual mandates with penalties for noncompliance.

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.

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Lifetime Limit – A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits or limits on specific benefits, or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

Long-term Care Insurance – Insurance policies that cover the costs of providing nursing care, home health care services and custodial care for the aged and infirm.

Managed Care – A system of health care delivery that is characterized by arrangements with selected providers, ongoing quality control and utilization review programs, and financial incentives for members to use providers and procedures covered by the plan.

Maximum Benefit – The maximum dollar amount that an insurance company will pay for claims, either for a specific procedure or service or during a specified period of time.

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.

Medical Loss Ratio (MLR) – A basic financial measurement used in the ACA to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has an MLR of 80%. With an 80% MLR, the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs and agent commissions. The ACA sets minimum MLRs for different markets, as do some state laws.

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.

Minimum Essential Coverage – The type of coverage an individual needs to have to meet the individual responsibility requirement under the ACA. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Open Enrollment Period – 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% of the allowable charges for covered services the rest of that calendar year.

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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."

Pre-existing Condition – Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.

Preferred Provider Organization (PPO) – A type of managed care plan in which health care providers and insurers agree to offer substantially discounted fees for covered health care services and to lower copays and deductibles for in-network services. The plan's payment ratio (what your insurance company pays compared to what you pay) may be high—for example, it could be 90/10, with the insurance company paying 90% of medical costs and you paying 10% after the copay and deductible.

Premium – The amount of money charged by an insurance company for coverage.

Prescription Insurance – Insurance that helps pay for prescription drugs and medications. Prescription insurance is often offered as part a larger health insurance plan, though this is not always the case. Stand-alone individual prescription insurance may be available for people who are not offered prescription drug coverage or who have no health insurance. Eligibility for specific medications and the cost of insurance varies among health plans. Also known as drug 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 Health Plan – An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

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.

Reasonable and Customary Charges – The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges are the responsibility of the patient.

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.

TRICARE – A health care program for active-duty and retired uniformed services members and their families.

Vision Insurance – Insurance that covers specific eye care benefits defined in the policy. Vision insurance policies typically cover routine eye exams and other procedures, and provide specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. Some vision insurance policies also offer discounts on refractive surgery.

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Waiting Period – A period of time in which your health plan does not provide coverage for a particular pre-existing condition.

Waiver – A rider or amendment to a policy that restricts benefits by excluding certain medical conditions from coverage.

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.