Employee Benefits Series

Health Insurance Glossary

FOR EMPLOYERS & PLAN PARTICIPANTS

PATTERSON SMITH ASSOCIATES, LLC

We design, build and manage employee benefit programs

Health Insurance Glossary

On occasion, there are questions about what a specific word or term means in the context of health insurance. This glossary is intended to serve as a tool to assist you in understanding some of the most common terms.

A

Affordable Care Act (ACA): The comprehensive health care reform law enacted in March 2010.

Affordable Coverage: An employer-sponsored health plan covering only the employee, the cost of which does not exceed a set annual percentage of the employee's household income. Click here for more information.

Allowed Amount: The maximum amount a plan will pay for a covered health care service. If a provider charges more than the plan's allowed amount, the plan participant may have to pay the difference through a process called balance billing.

Annual Limit: A cap on the benefits an insurance company will pay in a year while a plan participant is enrolled in a particular health insurance plan. Annual limits are sometimes placed on particular services such as prescriptions or hospitalizations, 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, the plan participant must pay all associated health care costs for the rest of the year.

B

Balance Billing: When a provider bills a patient for the difference between the provider's charge and the patient's insurance plan's allowed amount. For example, if the provider's charge is $100 and the patient's insurance plan's allowed amount is $70, the provider might bill the patient for the remaining $30.

Brand-Name Drug: A drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand-name drugs may be available by prescription or over the counter.

C

CHIP (Children's Health Insurance Program): Insurance program that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid, but not enough money to buy private insurance.

Claim: A request for payment of a benefit by a plan participant or his or her health care provider to the insurer for items or services the participant believes are covered by the plan.

COBRA (Consolidated Omnibus Budget Reconciliation Act): A federal law that may allow a plan participant or his or her dependents to temporarily keep their existing health coverage after certain qualifying events (such as the participant's employment ending or losing coverage as a dependent of a covered employee). Click here for more information.

Coinsurance: The percentage of costs of a covered health care service the participant pays after having paid his or her deductible.

Co-op Plan: A health plan offered by a non-profit organization in which the same people who own the company are insured by the company.

Copay (also known as copayment): A fixed amount the participant pays for a covered health care service after having paid his or her deductible.

Coverage: See **Health Insurance**.

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Cost Sharing: The share of costs covered by insurance that a plan participant pays out of his or her own pocket. Cost sharing generally includes deductibles, coinsurance, and copays, but does not include premiums.

D

Deductible: The amount a plan participant pays for covered health care services before his or her insurance plan starts to pay.

Dental Coverage: Benefits that help pay for the cost of visits to a dentist.

Dependent: A child or other individual for whom a parent, relative, or other person may claim a personal exemption that reduces their tax obligation.

Diagnostic Test: Test to figure out what the plan participant's health problem is. For example, an x-ray can be a diagnostic test to diagnose a broken bone.

Disability: A limit in a range of major life activities. This includes activities like seeing, hearing, and walking, and tasks such as thinking and working.

Drug List: See **Formulary**.

E

Emergency Medical Condition: An illness, injury, symptom (including severe pain), or condition severe enough that a reasonable person would seek medical attention right away.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Services: Services to check for or treat an emergency medical condition.

Employer Mandate: Provision of the Affordable Care Act that requires certain employers with at least 50 full-time employees (including full-time equivalents) to offer health insurance coverage to their full-time employees (and their dependents) that meets certain affordability and minimum value standards, or pay a penalty tax. The employer mandate is often referred to as "pay or play." Click here for more information.

Employer Shared Responsibility Provisions: See **Employer Mandate**.

Essential Health Benefits: A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more. Click here for more information.

Exchange: See **Health Insurance Marketplace**.

Excluded Services: Health care services that a plan does not pay for or cover.

F

Flexible Spending Arrangement (FSA): See **Health Flexible Spending Arrangement**.

Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. A formulary is also often called a drug list.

Fully Insured Plan: A health plan purchased by an employer from an insurance company.

G

Generic Drug: A drug that has the same active-ingredient formula as a brand-name drug.

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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. Grandfathered health plans are exempt from many changes required under the Affordable Care Act. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also provide consumers with contact information for questions or complaints.

Group Health Plan: In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

H

Health Care Provider: An individual or facility that provides health care services. Examples include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center.

Health Flexible Spending Arrangement (Health FSA): An arrangement an individual establishes through his or her employer to pay for out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copays and deductibles, and qualified prescription drugs, insulin, and medical devices. Contributions to an FSA are subject to an annual limit that is adjusted for inflation each year. These arrangements are also referred to as Health Flexible Spending Accounts.

Health Insurance: A contract that requires a health insurance company to pay some or all of a plan participant's health care costs in exchange for a premium.

Health Insurance Marketplace: A service that helps people shop for and enroll in health insurance. The federal government operates the Marketplace, available at HealthCare.gov, for most states. Some states run their own Health Insurance Marketplaces.

Health Maintenance Organization (HMO): A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. There are two main types of HMOs:

- **Traditional HMO**: This type of HMO provides no benefits for services obtained outside of a network.
- **Open-Access HMO**: This type of HMO allows enrollees to receive services from an out-of-network provider at a higher cost than the enrollee would pay at an in-network provider. The additional costs may be in the form of higher deductibles, copays, or coinsurance.

Health Reimbursement Arrangement (HRA): Employer-funded accounts from which employees are reimbursed tax-free for qualified medical expenses (for some types of HRAs, reimbursement is capped at a fixed dollar amount per year). Unused amounts may be rolled over to be used in subsequent years. Also referred to as a Health Reimbursement Account.

Health Savings Account (HSA): A type of savings account that allows an individual to set aside money on a pre-tax basis to pay for qualified medical expenses, if he or she has a high deductible health plan. HSA contributions are subject to an annual limit that is adjusted for inflation each year.

High Deductible Health Plan (HDHP): A plan with a higher deductible than a traditional insurance plan. To be considered an HDHP, the plan must meet minimum deductible and maximum out-of-pocket limit requirements, which are annually adjusted for inflation.

High-Risk Pool Plan: A state-subsidized health plan that provides coverage for individuals with expensive pre-existing health care conditions.

Home Health Care: Health care services and supplies an individual receives in his or her home under doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

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I

Individual Health Insurance Policy: Insurance policy for an individual who is not covered under an employer-sponsored plan.

Individual Mandate: Provision of the Affordable Care Act that requires every individual to have minimum essential coverage for each month, qualify for an exemption, or make a penalty payment when filing his or her federal income tax return. **Note:** Beginning in 2019, the individual mandate penalty was reduced to zero, so individuals will not be penalized for failing to obtain acceptable health coverage.

Individual Shared Responsibility Provision: See **Individual Mandate**.

In-Network: Health care providers (e.g., specialists, hospitals, laboratories) that have accepted contracted rates with the insurer in order to participate in the insurer's network. The insured person typically pays a lower price for using services within the network.

Inpatient Care: Health care that an individual receives when formally admitted as a patient to a health care facility, like a hospital or skilled nursing facility.

Internal Limit: Limitation that applies to individual categories of care—for example, a $250-per-procedure deductible for inpatient surgery.

L

Lifetime Limit: A cap on the total lifetime benefits a plan participant may receive from his or her insurance company. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

M

Mail-Order Drugs: Drugs that can be ordered through the mail.

Marketplace: See **Health Insurance Marketplace**.

Medicaid: A joint state and federal insurance program that provides free or low-cost health coverage to some low-income people, families, children, pregnant women, the elderly, and people with disabilities.

Medical Care: Services rendered by a hospital or qualified medical care provider.

Medical Loss Ratio (MLR): A basic financial measurement used in the Affordable Care Act 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 a medical loss ratio of 80%. A medical loss ratio of 80% indicates that 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 Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.

Medicare: A federal health insurance program for people aged 65 and older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). Medicare consists of four parts:

- **Medicare Part A**: Covers hospital, skilled nursing, nursing home, hospice, and home health services care.
- **Medicare Part B**: Covers medically necessary and preventive services.
- **Medicare Part C (Medicare Advantage)**: A type of Medicare health plan offered by a private company that contracts with Medicare to provide the beneficiary with all of his or her Part A and Part B benefits.

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- **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, both of which are offered by insurance companies and other private companies approved by Medicare.

Minimum Essential Coverage (MEC): Any insurance plan that meets the Affordable Care Act requirement for having health coverage (sometimes called qualifying health coverage). Individuals without minimum essential coverage may be subject to the individual mandate penalty.

Minimum Value: A standard of minimum coverage that applies to employer-sponsored health plans. Click here for more information.

N

Network: The facilities, providers, and suppliers a health insurer or plan has contracted with to provide health care services.

O

Obamacare: See **Affordable Care Act**.

Open-Access HMO: A type of HMO that allows enrollees to receive services from an out-of-network provider at a higher cost than the enrollee would pay at an in-network provider. The additional costs may be in the form of higher deductibles, copays, or coinsurance.

Open Enrollment Period: The yearly period when people can enroll in a health insurance plan.

Out-of-Network: Services received outside an insurer's network. These services typically carry a higher cost to the insured person.

Out-of-Pocket Costs: Expenses for medical care that are not reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copays for covered services, plus all costs for services that are not covered.

Out-of-Pocket Limit: The most a plan participant can be required to pay for covered services in a plan year. The out-of-pocket limit does not include monthly premium amounts or spending for services the plan does not cover. An out-of-pocket limit is also often called an "out-of-pocket maximum."

Out-of-Pocket Maximum: See **Out-of-Pocket Limit**.

Outpatient Care: Care received where a doctor has not written an order to admit the individual to a hospital as an inpatient (in these cases, an individual is an outpatient even if he or she spends the night in the hospital, but typically it does not require an overnight hospital stay).

P

"Pay or Play": See **Employer Mandate**.

Physician Services: Health care services a licensed medical physician provides or coordinates.

Plan Year: A 12-month period of benefits coverage under a group health plan. This 12-month period need not align with the calendar year.

Preauthorization: A decision by a health plan that a health care service or product is medically necessary. A health plan may require preauthorization for certain services before they are provided (except in an emergency), though preauthorization is not a promise by a health plan to cover the cost.

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Pre-Existing Condition: A health problem an individual had before the date that his or her new health coverage starts.

Pre-Existing Condition Exclusion Period: The period during which an insurance policy will not pay for care relating to a pre-existing condition.

Preferred Provider Organization (PPO): A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Under a PPO, a plan participant pays less in out-of-pocket costs if he or she uses providers that belong to the PPO's network.

Premium: The amount a plan participant pays for his or her health insurance every month.

Premium Tax Credit: A tax credit an individual can use to lower his or her premium when he or she enrolls in a plan through the Health Insurance Marketplace. The Premium Tax Credit is based on the income estimate and household information the individual provides on his or her Health Insurance Marketplace application.

Prescription Drugs: Drugs and medications that, by law, require a prescription.

Prescription Drug Coverage: A health plan that helps pay for prescription drugs and medications.

Preventive Services: Routine health care that includes screenings, check-ups, and patient counseling to prevent health problems.

Primary Care: Health services that cover a range of prevention, wellness, and treatment programs for common illnesses.

Primary Care Provider: A physician, nurse practitioner, clinical nurse specialist, or physician assistant who provides, coordinates, or helps an individual access a range of primary care services.

Q

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, copays, and out-of-pocket limits), and meets other requirements under the Affordable Care Act. All qualified health plans meet the minimum essential coverage requirement.

R

Referral: A written order from a primary care provider directing a patient to see a specialist or receive certain health care services. Under many health plans, a plan participant must obtain a referral before he or she can receive health care services from anyone except his or her primary care provider.

Rehabilitation Services: Health care services that help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because he or she was sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in a variety of inpatient and outpatient settings.

Rescission: The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel an entire individual health insurance policy if an individual made a mistake on his or her application for the policy that amounts to fraud or an intentional misrepresentation of material fact.

S

Screening: A type of preventive service that includes tests or exams to detect the presence of a health issue, usually performed when an individual has no symptoms, signs, or prevailing medical history of a disease or condition.

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Self-Insured Plan: Type of plan, usually present in larger companies, where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers often contract with a third-party administrator for services such as enrollment, claims processing, and provider networks.

Skilled Nursing Care: Services from licensed nurses in an individual's home or in a nursing home.

Special Enrollment Period (SEP): A time outside the yearly Open Enrollment Period when an individual can sign up for health insurance. An individual typically qualifies for a Special Enrollment Period as a result of certain life events, such as losing other health coverage, moving, getting married, having a baby, or adopting a child. By law, employer-sponsored plans must provide a special enrollment period of at least 30 days.

Specialist: A health care provider focusing on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Summary of Benefits and Coverage (SBC): An easy-to-read summary that allows an individual to make apples-to-apples comparisons of costs and coverage between health plans. An individual most commonly receives an SBC when he or she shops for coverage or renews or changes coverage.

T

Traditional HMO: A type of HMO that provides no benefits for services obtained outside of a network.

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

U

Urgent Care: Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe that it requires emergency room care.

Usual, Customary, and Reasonable Charge (UCR): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount is sometimes used to determine the allowed amount.

V

Vision Coverage: A health benefit that at least partially covers vision care, such as eye exams and glasses.

W

Waiting Period: The time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible for coverage under an employer-sponsored health plan.

Well-Baby/Well-Child Care: Routine doctor visits for comprehensive preventive health services that occur when a child is two years of age or younger, and annual visits until a child reaches age 21. Services include physical exams and measurements, vision and hearing screenings, and oral health risk assessments.

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Provided by:

Patterson Smith Associates, LLC
3 Elm Street - Suite 201
Morristown, NJ 07960

Phone: (800) 572-8859
www.psabenefits.com