Glossary of Health Care Terms

Health insurance is full of terms you may not know. To help you better understand health insurance, here's a list of the most commonly used health care terms and definitions.

A

Affordable Care Act

A comprehensive law passed in 2010, the Affordable Care Act was aimed at reforming America's health care system to improve access and affordability for more Americans.

Allowable Charge

The maximum amount a health plan will reimburse a doctor or hospital for a given service.

Annual Deductible

The amount you are required to pay annually before reimbursement by your health plan begins.

The deductible requirement does not apply to preventive services.

Annual Limit

An insurance plan may limit the dollar amount it will pay during one year for a certain treatment or service, or for all benefits provided in a year.

Authorization

Obtaining approval from the primary care physician as well as health plan (depending on the plan's specifications) prior to receiving health care services, such as visiting specialists, obtaining radiology scans and undergoing surgical procedures.

B

Benefits

The health care items or services covered by a health plan. Your health plan may sometimes be referred to as a "benefits package."

C

Catastrophic Plan

The health insurance exchange will include a catastrophic plan option. Catastrophic plans have lower premiums but begin to pay only after you've first paid a certain amount for covered services, or just cover more expensive levels of care, like hospitalizations. Catastrophic plans are an option to consider for young adults and people for whom coverage would otherwise be unaffordable.

Claim

An itemized bill filed by a health care provider to a member (patient's) insurance, for health services provided.

Claim Form

A form you or your doctor fill out and submit to your health plan for payment.

COBRA

This stands for Consolidated Omnibus Budget Reconciliation Act of 1985. This federal act requires group health plans to allow employees and covered dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, termination of employment, a child becoming an over-aged dependent, Medicare eligibility, death or divorce of a covered employee, among others.

Coinsurance

The **percentage of the costs** of a covered health care service or prescription drug you pay after you've paid your deductible. You pay 100 percent of the full allowed amount **until** you meet your deductible.

The share of health care services paid by an enrollee. Coinsurance is generally found in conjunction with a deductible. Once the deductible is met, the enrollee is typically responsible for a specified percentage of the medical bill.

Consumer Directed Health Plan (CDHP)

A health plan with a health savings account (HSA) or other tax-advantaged account. Consumer directed health plans give members more control of health care expenses, as the deducible is higher and care is paid for with the health savings account.

Contracting Hospital

A hospital that has contracted with a particular health plan to provide hospital services to members of that plan.

Coordination of Benefits

When you need care and are on two different health plans, your insurers will coordinate your benefits to give you maximum coverage when you need it. It helps avoid duplicate payments and ensure the right payments are made by each plan.

Copay

The **set dollar amount** you pay for a covered health care service at the time you get care or when you pick up a prescription drug.

The fixed fee paid by the enrollee at the time of service such as office and emergency room visits. Co-payments are generally charged by health maintenance organizations (HMOs), point-of-service plans (POS) and some preferred provider organization (PPO) plans

Cost-Sharing Reduction (CSR)

A discount that lowers the amount you have to pay out-of-pocket for deductibles, coinsurance, and copayments. You can get this discount if your income is below a certain level and you choose a health plan from the Silver plan category. If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.

Covered Benefit

A health service or item that is included in your health plan and that is paid for either partially or fully.

Covered Charges

Services or benefits that a health plan makes either partial or full payment.

Covered Person

The eligible person enrolled in the health plan and any enrolled eligible family members.

Covered Service

A service that is covered according to the terms in your health plan.

D

Deductible

The amount you pay for most covered services **before your health plan starts to pay**. When you go to a provider that is in the plan's network, before you meet the deductible you may pay a **discounted amount** that has been negotiated with the provider. The deductible resets at the beginning of the calendar year or when you enroll in a new plan. The annual amount paid by the enrollee for services. The deductible must be met before the insurer pays for services.

Dependent

An eligible person, other than the member (generally a spouse or child), who has health care benefits under the member's policy.

Drug Formulary

A list of preferred drugs chosen by a panel of doctors and pharmacists. Both brand and generic medications are included on the formulary.

E

Effective Date of Coverage

The date your coverage begins. Please note that the effective date can also represent the date a change in your coverage takes effect. If you have questions, call the number on the back of your ID card.

Emergency Medical Care

Services provided for the initial outpatient treatment of an acute medical condition, usually in a hospital setting. Most health plans have specific guidelines to define emergency medical care.

Employer Responsibility

Starting in 2015, if an employer with at least 50 full-time-equivalent employees doesn't provide affordable health insurance and an employee uses a tax credit to help pay for insurance through the Health Insurance Marketplace, the employer must pay a fee to help cover the cost of tax credits.

Enroll

To join a health plan

Essential Health Benefits

Some benefits will be included in every health plan. Beginning in 2014, most insurance plans you can choose from — whether you buy on the Health Insurance Marketplace or go directly to the insurance company of your choice — will include many benefits that are meant to make sure basic health concerns are covered. For example, preventive care screenings and annual wellness exams are covered with any plan you buy.

Exclusions

Specific medical conditions or circumstances that are not covered under a health plan.

Exclusive Provider Organization (EPO)

This managed care plan is similar to an HMO plan in that members must choose a primary care physician. The health plan administers the plan and pays providers directly. If specialty services are not authorized, the plan usually does not cover the services.

Explanation of Benefits (EOB)

An EOB is created after a claim payment has been processed by your health plan. It explains the actions taken on a claim, such as the amount that will be paid, the benefit available, discounts, reasons for denying payment and the claims appeal process. EOBs are available as a paper copy or electronically.

F

Family Coverage

Health care coverage for a primary policyholder (called a "subscriber") and their spouse and any eligible dependents.

Federal Poverty Level (FPL)

The income level of an individual or household, issued annually, used by the Department of Health and Human Services to determine eligibility for certain programs and benefits. FPL will be used to determine the amount of tax credit you qualify for to offset the cost of buying health insurance.

G

Gatekeeper

The primary care physician in a managed care plan through which all other care (e.g., visits to specialists and other providers, lab and radiology tests, hospitalizations, etc.), with the exception of emergencies, must be coordinated.

Generic Drug

A prescription drug that is the generic equivalent of a brand name drug listed on your health plan's formulary and costs less than the brand name drug.

Grandfathered Health Plan

A health plan that was in place when the Affordable Care Act was passed into law in 2010. A grandfathered plan is exempt from some requirements of the law. The grandfather rule allows businesses and families to keep the plan they have, if they wish to.

Group Plan

A group of people covered under the same health plan and identified by their relation to the same employer or organization.

Guaranteed Issue

A requirement under the Affordable Care Act that health insurers must permit you to enroll in some form of insurance coverage regardless of health status, age, gender or other factors.

H

Health Insurance Marketplace

The Health Insurance Marketplace, or Health Insurance Exchange, is a federal government website where you can shop, compare and buy plans offered by participating health insurance companies in your area. You can access the Marketplace at Healthcare.gov , through Blue Cross and Blue Shield of Illinois or by phone.

Health Maintenance Organization (HMO)

A type of health plan that provides health care coverage to its members through a network of doctors, hospitals and other health care providers. An HMO may cost less than other plans but has some limitations.

Health Savings Account

With a Health Savings Account, or HSA, you set aside money before taxes. When you visit a doctor or go to a hospital, you can pay for qualified expenses from your HSA. Only certain plans meet the high deductible amounts needed for you to be able to use your HSA.

HIPAA

A federal law that outlines the rules and requirements plans must follow to provide health care insurance coverage for individuals and groups.

I

Independent Practice Association (IPA)

An organization of providers who have joined together for the purpose of entering into HMO contracts to provide medical care as a participating medical group.

Individual & Family Out-of-Pocket Maximums

The most you have to pay for covered services in a plan year other. After you spend this amount on deductibles, copays and coinsurance, your health plan pays 100 percent of the costs of covered benefits. For plans that cover more than 1 person, individual out-of-pocket maximums counts toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is reached, the plan pays 100 percent of the cost of covered benefits for everyone on your plan. The out-of-pocket maximum doesn't include your monthly premium payments or anything you spend for services your plan doesn't cover.

Individual Coverage HRA (ICHRA)

Starting January 1, 2020, employers can offer their employees an individual coverage Health Reimbursement Arrangement (HRA) instead of a traditional group health plan. This type of account may help reimburse qualifying health care expenses. As examples, these expenses could be monthly premiums and out-of-pocket costs, such as copays and deductibles.

Individual Health Plan

Health care coverage for an individual with no covered dependents. Also knows as individual coverage.

Infusion Drug Care

Infusion drug treatments are often used for chronic "maintenance" conditions like asthma, immune deficiencies or rheumatoid arthritis. The drugs are often covered under your health plan's medical benefit, not the drug benefit. Where you get this care could change your out-of-pocket costs.

In-network

This refers to doctors, hospitals, pharmacies and other health care providers that have agreed to provide members of a certain insurance plan with services and supplies at a discounted price. Under some insurance plans, your care is covered only if you get it from in-network providers.

Inpatient Services

Services provided when a member is registered as a bed patient in a health care facility, such as a hospital.

Insured Person

The person who a contract holder (an employer or insurer) has agreed to provide coverage for, often referred to as a member/subscriber.

J

K

L

Lifetime Limit

A cap on the total benefits you may get from your insurance company over the life of your plan **for certain conditions**. A health plan may have a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like one gastric bypass per lifetime), or a combination of the two. After a lifetime limit is reached, the health plan will no longer pay for covered services. There are no lifetime limits on essential health benefits, such as emergency services and hospital stays.

M

Medicaid

A joint federal and state funded program that provides health care coverage for low-income children and families, and for certain aged and disabled individuals.

Medical Group

A group of doctors and other health professionals that have a shared medical practice and contract with a health plan to deliver health care services to plan members.

Medicare

A federally funded health insurance program for patients who are disabled or over age 65. The original Medicare plan has two parts — Part A is hospital insurance with coverage including hospitalization, hospice and skilled nursing facility services. Medicare Part B is medical insurance with coverage including physician services, medical supplies and clinic care.

Medicare Advantage

These are health plan options approved by Medicare but run by private companies. They are part of the Medicare program. You may have to use the plan's doctors and hospitals to get services

Medicare Supplement

A supplemental insurance policy to help cover the difference between approved medical charges and benefits paid by Medicare. These plans are also known as "Medi-gap" plans.

Member

The person to whom health care coverage has been extended by the policyholder (such as their employer) or any of their covered family members. Sometimes referred to as the insured or insured person.

Minimum Essential Coverage (MEC)

The type of health coverage an individual needs to maintain throughout the year in order to meet the individual responsibility requirement under the Affordable Care Act. Health plans that are considered MEC include individual, and family plans bought through the Health Insurance Marketplace, qualified health plans bought directly through an insurance company such as Blue Cross and Blue Shield of Illinois, job-based coverage, Medicare, Medicaid, and certain other coverage.

N

Network

The group of doctors, hospitals and other health care professionals that contracts with a health plan to deliver medical services to its members.

Non-Contracting Hospital

A hospital that has not contracted with a particular health plan to provide hospital services to members in that plan.

O

Open Enrollment Period

The period of time set up to allow you to enroll in a health plan, usually once a year.

Out of Network

Services are considered out of network when you use a doctor or other provider that does not have a contract with your health plan. Out-of-network services may not be covered or may be covered at a lower level. You may be responsible for all or part of an out-of-network provider's bill.

Out-of-Pocket Maximum

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copays and coinsurance, your health plan pays 100 percent of the costs of covered benefits. The out-of-pocket maximum doesn't include your monthly premium payments or anything you spend for services your plan doesn't cover.

Outpatient Services

Treatment that is provided to a patient who is able to return home after care without an overnight stay in a hospital or other inpatient facility.

P

Participating Provider Option (PPO)

A health plan that supplies services at a higher level of benefits when members use contracted health care providers. PPOs also provide coverage for services rendered by health care providers who are not part of the PPO network; however, the plan member generally shares a greater portion of the cost for such services.

Pharmacy Benefit Manager (PBM)

A separate, or third-party, company that handles your health plan’s pharmacy benefit. A PBM processes and pays for your prescription drug claims based on the terms of your pharmacy benefit.

Precertification

Obtaining approval from a health plan for an elective hospital stay, prior to admission to the hospital. Expected length of stay is also determined during precertification.

Premium

The ongoing amount that must be paid for your health plan. You and/or your employer usually pay it monthly, quarterly or yearly. The premium may not be the only amount you pay for insurance coverage. Typically, you will also have a copay or deductible amount.

Premium Tax Credit

Based on your family size and income, you may qualify for a tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly premium costs. Sometimes called an advanced premium tax credit (APTC), or tax credit.

Prescription Drugs

Prescription drugs must be ordered by a doctor and obtained at a pharmacy. They are reviewed and approved through a formal process set by the U.S. Food and Drug Administration (FDA).

Prescription Drug List

A list of commonly prescribed drugs (also known as a drug formulary). Not all drugs listed in a plan's prescription drug list are automatically covered under that plan.

Prescription Drug Payment Level Tier

A prescription drug list has different levels of payment coverage, called “tiers." These tiers determine how much you will pay out of pocket for your prescription drug, based on the terms of your pharmacy benefit and whether the drug is covered on the drug list. Drugs in a lower tier will often cost less than drugs in a higher tier.

Preventive Care Services

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Physician (PCP)

The physician you choose to be your primary source for medical care. Your PCP coordinates all your medical care, including hospital admissions and referrals to specialists. Not all health plans require a PCP.

Prior Authorization

The process by which a plan member or their doctor gets approval from their health plan before the member undergoes a course of care, such as a hospital admission or a complex diagnostic test. Also called preauthorization.

Provider

A licensed health care facility, program, agency, doctor or health professional that delivers health care services.

Q

Qualified Health Plan

A health plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (deductibles, copays, and out-of-pocket amounts) and meets other requirements.

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

Small companies may offer their employees a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) if they don’t offer group health coverage. This kind of account may help pay for things like monthly premiums or other qualifying health care costs.

Quantity Limits

A quantity limit is the highest amount of a prescription drug that can be given to you by your pharmacy in a period of time (for example, 30 tablets per month). Some drugs have quantity limits to help encourage appropriate usage, ensure effectiveness and reduce costs.

R

Referral

A referral is when a physician sends a patient to another physician for a specific, usually complex problem.

Required for an HMO or point-of-service (POS) coverage, a written authorization from a member's primary care physician (PCP) to receive care from a different contracted doctor, specialist or facility.

S

Specialist

A health care professional whose practice is limited to a certain branch of medicine, including specific procedures, age categories of patients, specific body systems or certain types of diseases.

Special Enrollment Period

A time outside the open enrollment period during which you can sign up for health insurance. You generally qualify for a special enrollment period of 60 days following certain life events that change your family status (for example, marriage or birth of a child) or loss of other health coverage.

Specialty Drug

A prescription drug used to treat complex health conditions. These drugs are usually given as a shot but may be added to the skin or taken by mouth. Also, they may:

- Require following a specific treatment plan
- Have special handling or storage needs
- Not be sold in retail pharmacies

Conditions like hepatitis C, hemophilia, multiple sclerosis and rheumatoid arthritis are treated with specialty drugs.

Step Therapy

Step therapy is also known as “fail first” when your insurance company requires certain steps before they’ll pay for your medication. Usually, this means you’ll have to try taking a preferred medication before they’ll pay for a non-preferred one.

Subsidy (Also Known As Premium Tax Credit)

Based on your family size and income, you may qualify for a subsidy, also known as a premium tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly premium bill.

T

U

Utilization Management

The way insurance plans review the type and amount of care you're getting. This involves looking at the setting for your care and its medical necessity. Insurers may use prior authorization, step therapy, quantity limits, case management, and/or accompanying reviews.

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