Click on a letter to go directly to that portion of the glossary:

A

Accidental death and dismemberment (AD&D): This benefit can be paid in two ways. It can be paid to the insured person after an accidental injury. Or it can be paid to someone else after the death of an insured person.

Patient Protection and Affordable Care Act (ACA): This is also known as the Affordable Care Act or ACA. The first part of the comprehensive health care reform law enacted on March 23, 2010. The law was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is usually used to refer to the final, amended version of the law. The law provides numerous rights and protections that make health coverage more fair and easy to understand, along with subsidies (through “premium tax credits” and “cost-sharing reductions”) to make it more affordable. The law also expands the Medicaid program to cover more people with low incomes.

Accountable care organization (ACO): A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Accreditation: If a Marketplace health plan is approved, this is the “seal of approval” given to the plan by an independent organization to show that the plan meets national quality standards.

Active full-time employee: This is a person who works a normal workweek for an employer. Employees must work at least the number of hours shown in a plan's Schedule of Insurance.

ADA: Also known as the Americans with Disabilities Act. This law protects the rights of people with disabilities. It helps prevent them from being treated unfairly on the job.

Administrative Services Organization (ASO): A managed care administrative entity that performs certain tasks for managed care companies and insurers. An ASO is not an insurance plan and is not licensed to sell insurance.

Admission: Overnight or inpatient admittance to an acute care general hospital, skilled nursing facility, birthing center or mental health facility.

Admitting Privileges: The right or privilege granted to a physician to admit patients to a particular hospital.

Adjudication: This is the way health plans decide how much they will pay for certain expenses.

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

Agent: An agent or broker is a person or business who can help you apply for help paying for coverage and enroll you in a Qualified Health Plan (QHP) through the Marketplace. They can make specific recommendations about which plan you should enroll in. They're also licensed and regulated by states and typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer's plans. Some agents and brokers may only be able to sell plans from specific health insurers.

Allowable expense(s): This is the part of a bill that is eligible to be paid under your health plan.

Allowed amount: The maximum amount a plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate." If your provider charges more than the plan's allowed amount, you may have to pay the difference.

Check your plan documents for more details: Your health plan documents will tell you how we pay for out-of-network care and how we calculate the allowed amount.

Ambulatory surgery: Also known as an outpatient procedure. Some procedures can be done in a hospital, surgery center or doctor's office. The person gets it done and goes home. There is no overnight stay.

American Medical Association (AMA): The professional association representing physicians in the United States.

Americans with Disabilities Act (ADA): This law protects the rights of people with disabilities. It helps prevent them from being treated unfairly on the job.

Ancillary services: These are services provided to support your health care. Some examples include X-rays or lab tests.

Annual coordinated election period (AEP): This is a time when you can make changes to your Medicare plan.

Appeal: A request for your health insurance company or the Health Insurance Marketplace to review a decision that denies a benefit or payment.

- If you don't agree with a decision made by the Marketplace, you may be able to file an appeal. You can also appeal decisions by the SHOP Marketplace for small businesses.
- If your health plan refuses to pay a claim or ends your coverage, you have the right to appeal the decision and have it reviewed by a third party.

Appeals process: This process lets you ask for a review of claims that have been denied by your health plan.

APR-DRGs: Also known as All Patient Refined Diagnosis Related Groups. A patient classification system, developed by the 3M Corporation, that uses hospital patient discharge data and computer-based logic to assign patients to severity of illness and risk of mortality classes so they can be accurately compared in terms of length of stay, resource consumption, and outcomes.

Authorization: This is an important process. It is approval* a person gets for care before receiving care. This helps people know if the care is covered by a health plan. This can also be called:

- Precertification
- Certification
- Prior authorization

**In Texas, this approval is known as a pre-service utilization review and is not verification as defined by Texas law.*

B

Balance billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Bariatric surgery: This is weight-loss surgery. It is for very overweight people who haven't lost weight with diet and exercise. Doctors perform two types. One makes the stomach smaller. The other bypasses part of the intestine.

Basic Dental Care: Dental services, such as fillings, extractions and anesthesia.

Bed Days: This is the total number of days of hospital care (excluding day of discharge) provided to a health plan member.

Behavioral health: This is also called mental health. It describes a person's state of mind. Depression, eating disorders and substance abuse are conditions that fall under this term.

Beneficiary (Medicare/Medicaid): This is someone who has a health plan under Medicare or Medicaid.

Benefits: Health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

Benefit period: A period of consecutive days during which medical benefits for covered services are available to the plan member.

Best Practice: A technique, methodology, or action that, through experience and/or research, has proven to lead to a desired result.

Board certified: This describes health care practitioners who have met national standards for knowledge, skills and experience in a specialty area. These practitioners include doctors, physician assistants, dentists, pharmacists and nurses.

Brand-name drug: A drug sold by a drug company under a specific name or trademark. Brand-name drugs may be available by prescription or over the counter.

Broker: An agent or broker is a person or business who can help you apply for help paying for coverage and enroll in a Qualified Health Plan (QHP) through the Marketplace. They can make specific recommendations about which plan you should enroll in. They're also licensed and regulated by states and typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer's plans. Some brokers may only be able to sell plans from specific health insurers.

Bronze health plan: See "Health plan categories."

C

Capitation: This is a fixed amount of money doctors and hospitals get from health plans to serve plan members. They get this amount no matter how many patients they see.

Case management: This is the way health plans help people with complex care needs. Case managers help coordinate care to help people improve their health.

Catastrophic Illness: Serious or life-threatening health problems that can result in financial hardship without the appropriate health care coverage.

Centers for Disease Control and Prevention (CDC): The federal agency charged with protecting the public health by providing leadership and direction in the prevention and control of diseases; it also responds to public health emergencies.

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace. For more information, visit cms.gov

Certificate of coverage: This details the benefits provided by your health plan. It lists what is covered and what is not covered. You will get this document after you sign up for a plan.

Certificate of Creditable Coverage: Documentation of proof of prior insurance coverage.

Certification: This important process is the approval* a person gets for care before receiving the care. This helps people know if the care is covered by a health plan. People should check with their plan to see what kind of service needs this approval. This can also be called:

- Precertification
- Authorization
- Prior authorization

**In Texas, this approval is known as pre-service utilization review and is not verification as defined by Texas law.*

Chemotherapy: This is a cancer treatment. It involves chemical or biological drugs. These drugs are usually given through a vein.

Child Health Insurance Program (CHIP): Insurance program that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid but not enough to buy private insurance. In some states, CHIP covers pregnant women. Each state offers CHIP coverage and works closely with its state Medicaid program. You can apply any time. If you qualify, your coverage can begin immediately, any time of year.

Chiropractic care: This therapy is used to help treat the spine, joint pain and movement problems. A licensed chiropractor gives this care.

Claim: A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.

Closed formulary: A formulary is a list of prescription drugs the health plan covers. If the plan has a closed formulary, it only covers drugs that are on that list. It will not cover any part of the cost of non-formulary drugs. However, in some instances, a plan may be willing to make an exception. To get an exception, you need to contact the plan and tell them why the drug is needed.

CMS: Also known as Centers for Medicare & Medicaid Services. This is a federal agency. It runs the Medicare program. It also works with states to run the Medicaid program.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986): COBRA is the continuation of coverage law. It requires most group health plans to offer a temporary continuation of group health coverage in certain circumstances. COBRA covers eligible employees, their spouses, former spouses and dependent children. If elected, it enables them to keep their coverage when it would otherwise be lost due to:

- The death of a covered employee
- Termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct
- Divorce or legal separation from a covered employee
- A covered employee becoming entitled to Medicare
- A child's loss of dependent status (and therefore coverage) under the plan

Coinsurance: The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible. Let's say your health insurance plan's allowed amount for an office visit is $100 and your coinsurance is 20%.

- If you've paid your deductible: You pay 20% of $100, or $20. The insurance company pays the rest.
- If you haven't met your deductible: You pay the full allowed amount, $100.

Generally speaking, plans with low monthly premiums have higher coinsurance, and plans with higher monthly premiums have lower coinsurance.

Complication of pregnancy: This is a health problem that happens during pregnancy. It is something that would not happen in a normal pregnancy. It can affect the baby, the mother or both.

Consumer-directed health plan: This plan helps you control more of your health benefit dollars. It includes a fund or account that can be used to pay for your medical expenses. Most health funds allow unused dollars to be rolled over from year to year, for as long as you stay in the plan. Some plans allow the fund to go with you, even if you change jobs.

Contract (also known as a benefit certificate or policy): This is a legal agreement. It is between a customer (an individual or group) and an insurance plan. It lists all details of the plan's coverage.

Contract holder: This is a legal term. It is a customer (an individual or group) who buys an insurance plan from an insurer.

Coordination of benefits (COB): A way to figure out who pays first when 2 or more health insurance plans are responsible for paying the same medical claim. These rules are used to decide which plan pays first for people who have more than one plan. This helps coordinate coverage and allows claim information to be shared by the plans. This way, the plans can avoid duplicate payments.

Copayment: Also known as "copay". This is the dollar amount you pay for health care expenses. In most plans, you pay this after you meet your deductible limit. For example, you pay a set dollar amount to your doctor for an office visit. So, if your copay is $25, you pay that amount when you go to your doctor. Copays are also used for some hospital outpatient care services in the original Medicare plan. In prescription drug plans, it is the amount you pay for covered drugs. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists. Generally plans with lower monthly premiums have higher copayments. Plans with higher monthly premiums usually have lower copayments.

Coverage: Services eligible to be paid for by your health plan.

Covered services (also covered benefits or covered expenses): These are services or supplies your health plan covers. They are eligible to be paid by your plan.

Credentialing: This is a process. It is used to be sure doctors and hospitals meet certain standards. It is also used for other health professionals and facilities.

Creditable coverage: Also known as prior creditable coverage. This term means types of health coverage a person has had. People sometimes need to prove they have had this so they can be fully covered by a new plan. Some examples of acceptable types are:

- Group or individual coverage
- Medicare
- Medicaid
- Health care for members of the uniformed services
- A program of the Indian Health Service
- A state health benefits risk pool
- The Federal Employees' Health Benefit Program
- A public health plan (any plan established by a state, the government of the United States, or any subdivision of a state or of the government of the United States, or a foreign country)
- Any health benefits plan under Section 5(e) of the Peace Corps Act
- The State Children's Health Insurance Program (S-CHIP)

Creditable coverage—Medicare: This applies to people who are eligible for Medicare. It is coverage that is at least as good as the Medicare drug plan. If you have such a prescription drug plan, you can stay in your plan. You will not be charged higher fees if you switch to Medicare later.

Customary and reasonable: A limit on the amount your health plan will pay. Also called usual, customary and reasonable (UCR), reasonable, or prevailing charge. The limit is based on data we receive. The data is based on what doctors charge for the health care service.

D

Date claim incurred (DCI): This is for disability plans. It is the date a person becomes disabled.

Date claim received: This is the date the insurance company receives the claim.

Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

- Many plans pay for certain services, like a checkup or disease management programs, before you've met your deductible. Check your plan details.
- All Marketplace health plans pay the full cost of certain preventive benefits even before you meet your deductible.
- Some plans have separate deductibles for certain services, like prescription drugs.
- Family plans often have both an individual deductible, which applies to each person, and a family deductible, which applies to all family members.

Generally, plans with lower monthly premiums have higher deductibles. Plans with higher monthly premiums usually have lower deductibles.

Deductible (Medicare): This is what you must pay for health care before the Medicare plan begins to pay. This amount can change each year.

Defined contribution plans: There are many different types of these plans. In them, employers give each worker a fixed amount of money. The worker can use the money for retirement, health or some other benefit. When the plan is for health benefits, the money can be used to pay for health insurance or health services.

Dependent: A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the Affordable Care Act, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents.

Diagnostic tests: These are tests that a health care professional orders. The tests help see if a person has a condition or a disease. X-rays and ultrasounds are examples of these tests.

Diagnosis-Related Group (DRG): A statistical system of classifying any inpatient stay into groups for the purposes of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of Medicare reimbursement.

Disease management: This is a type of program that comes with some health plans. It is used to help people who live with a chronic illness. It helps members manage their health and prevent future problems.

DME: Also known durable medical equipment. Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

For Medicare patients: These are devices that doctors order for use in the home. They must be reusable. Some examples are walkers, wheelchairs or hospital beds. They are covered under Medicare Part A and Part B for home health services.

Doctor Office Visit: Going to a licensed physician's office.

Domestic partners: This means two people who live together but are not married. They are responsible for each other's well-being and finances. They may or may not be a same-sex couple.

Donut hole (Medicare): Also known as coverage gap. Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

Drug: This is a natural or man-made substance used to treat an illness.

Drug formulary: Also known as a formulary. This is a list of prescription drugs the health plan covers. It can include drugs that are brand name and generic. Drugs on this list may cost less than drugs not on the list. How much a plan covers may vary from drug to drug. An open formulary provides a greater choice of covered drugs. It is also called a preferred drug list.

Drug tiers: These are groups of different drugs. Usually, the plans group the drugs by price. Each group or tier requires a different copay. You might see the groups listed as generic, brand-name, or preferred brand-name drugs. Generic drugs often have lower copays. Brand-name drugs have higher copays.

Dual eligibles (Medicare): These are people who can get benefits through two plans: Medicare and Medicaid.

Durable medical equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Durable medical equipment (DME) (Medicare): These are devices that doctors order for use in the home. They must be reusable. Some examples are walkers, wheelchairs or hospital beds. They are covered under Medicare Part A and Part B for home health.

E

EAP: Also known as employee assistance program. This can help people balance work and life issues. It gives support and counseling to help people deal with stress, family issues and more. The program is for employees, their dependents and household members. Employers buy it. Workers do not pay to use an EAP.

Effective date: This is the date your health plan becomes active. Your coverage starts on this day.

Eligibility: This includes terms that decide who can get coverage. The requirements vary. They could include health conditions, how long a person is employed, job status and more.

Emergency: This is a serious illness or injury. It comes on suddenly. It is something that needs immediate medical care. If a person does not get care quickly, death or serious health problems may occur.

Emergency facility: This is a place that offers short-term care on the spot. People usually go to one when they have a sudden illness or injury. Two examples are hospitals and clinics.

Emergency Room (ER): Also known as an Emergency Department (ED), is a hospital department responsible for providing immediate medical or surgical care.

Employee assistance program (EAP): This can help people balance work and life issues. It gives support and counseling to help people deal with stress, family issues and more. The program is for employees, their dependents and household members. Employers buy it. Workers do not pay to use an EAP.

Employee Retirement Income Security Act of 1974 (ERISA): This is a law. It controls employer-based health plans. It also sets rules for pensions and other benefits plans.

Electronic health record (EHR): This is a digital version of a patient's medical history. The goal is that all professionals involved in a patient's care enter details into this record. That could be your primary doctor or specialist. Or pharmacies, hospitals and labs.

The EHR might include details like medicine taken, lab results and vital signs.

Patient information can now be easily seen and shared across all providers. So there's a broader view of a patient's health.

Enrollee: Also known as a member. A member is someone who belongs to a health plan. Sometimes a member is known as an enrollee.

Enrollment period (Medicare): This is when people can sign up for a Medicare health plan. At this time, the plan accepts people new to Medicare. The plan must also allow all eligible people with a different Medicare plan to join.

EOB: See "Explanation of Benefits." This is a statement a health plan sends to a health plan member. It shows charges, payments and any balances owed. It may be sent by mail or e-mail.

EOI: See "Evidence of insurability."

ERISA: Also known as the Employee Retirement Income Security Act of 1974. This is a law. It controls employer-based health plans. It also sets rules for pensions and other benefits plans.

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. Some plans cover more services. Plans must offer dental coverage for children. Dental benefits for adults are optional. Specific services may vary based on your state's requirements. You'll see exactly what each plan offers when you compare plans.

Evidence-based medicine: This is when doctors use the latest research findings to help them make decisions on patient care. They combine it with their own expertise and what they learn from the patient.

Evidence of insurability (EOI, also known as medical underwriting): A group or individual might have to go through this process when applying for health or life insurance. EOI may also be needed when someone wants more coverage or is enrolling late. It helps the insurer decide whether to cover the person or group. The process might include:

- An EOI statement -- questions about health conditions answered by an applicant
- Medical exam
- Tests, such as on the heart
- Report from the applicant's doctor
- Other information, if needed

Exchange: Another term for the Health Insurance Marketplace, a service available in every state that helps individuals, families, and small businesses shop for and enroll in affordable medical insurance. The Marketplace is accessible through websites, call centers, and in-person assistance. When you fill out a Marketplace application, you'll find out if you qualify to save money when you enroll in a medical insurance plan. You'll also find out if you qualify for Medicaid and the Children's Health Insurance Program (CHIP). Whether you qualify for these programs depends on your expected income, household members, and other information.

Exclusions: Health care services that your health insurance or plan doesn't pay for or cover.

Exclusive Provider Organization (EPO): This is a type of preferred provider organization where the patient must "exclusively" use the providers within the PPO.

Experimental services or procedures: These are often newer drugs, treatments or tests. They are not yet accepted by doctors or by insurance plans as standard treatment. They may not be proven as effective or safe for most people.

Explanation of Benefits (EOB): This is a statement a health plan sends to a health plan member. It shows charges, payments and any balances owed. It may be sent by mail or e-mail.

F

Family and Medical Leave Act (FMLA): A Federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off due to serious illness or disability, to have or adopt a child, or to care for another family member. When on leave under FMLA, you can continue coverage under your job-based plan.

Federal poverty level (FPL): A measure of income issued every year by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

Federally Facilitated Marketplace (FFM): An organized marketplace for health insurance plans operated by the U.S. Department of Health and Human Services (HHS). The FFM opened for enrollments starting October 1, 2013.

Federally qualified health center (FQHC): Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of your ability to pay. Services are provided on a sliding scale fee based on your ability to pay.

Fee for service: A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Flexible spending account (FSA): An arrangement you set up through your employer to pay for many of your out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles, and qualified prescription drugs, insulin and medical devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. You don't have to pay taxes on this money. Your employer's plan sets a limit on the amount you can put into an FSA each year.

There is no carry-over of FSA funds. This means that FSA funds you don't spend by the end of the plan year can't be used for expenses in the next year. An exception is if your employer's FSA plan permits you to use unused FSA funds for expenses incurred during a grace period of up to 2.5 months after the end of the FSA plan year.

Note: Flexible Spending Accounts are sometimes called Flexible Spending Arrangements.

FMLA: Also known as the Family and Medical Leave Act. A Federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off due to serious illness or disability, to have or adopt a child, or to care for another family member. When on leave under FMLA, you can continue coverage under your job-based plan.

Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Formulary exclusion list: This is a list of prescription drugs not covered by a health plan. It applies to closed formulary plans. If a member needs a drug on this list, the doctor must ask the plan to cover it as an exception. The plan will only do so if use is medically necessary.

FSA: See "Flexible spending account."

Fully insured employers: These employers pay the health plan provider to administer and manage the benefits they've chosen. The insurer pays the claims. This means the insurer is the one taking the risk.

G

Generic drug: 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.

Gold health plan: One of 4 health plan categories (or "metal levels") in the Health Insurance Marketplace. Gold plans usually have higher monthly premiums but lower costs when you get care. Gold may be a good choice if you use a lot of medical services or would rather pay more up front and know that you'll pay less when you get care.

See also "Health plan categories."

Grievance: A complaint that you communicate to your health insurer or plan.

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

Group insurance: Also known as group coverage. This is a plan offered by a plan sponsor to an employee group or other group. The plans offer health, dental, life insurance coverage and more. Group plans may also be offered to retirees.

Guaranteed Health Coverage: For plans with effective date January 1, 2014, no one can be rejected for health coverage because of medical history.

H

HDHP: Also known as a High-Deductible Health Plan. A plan with a higher deductible than a traditional insurance plan. Usually the monthly premium is lower, but you have to pay more health care costs yourself (your deductible) before the insurance company starts to pay its share. A high deductible plan can be combined with a health savings account or a health reimbursement arrangement. This allows you to pay for certain medical expenses with untaxed dollars.

For 2016, the IRS defines a high deductible health plan as any plan with a deductible of at least $1,300 for an individual or $2,600 for a family.

Health assessment: A health assessment is a form or online tool to help you find out how healthy you are. It also helps you see if you are at risk for future illnesses. It gathers information by asking a series of questions. It may be used to help decide which health programs would be good for you.

Health benefits plan: This is any plan that helps pay for health care services. There are many types of plans. Some are limited to certain types of services. Some plans cover only hospitalizations, for example. Some plans offer open access to doctors. Some offer access to network doctors only.

Health insurance carrier: This is a company that provides health insurance plans.

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

The Health Insurance Marketplace (also known as the "Marketplace" or "exchange") provides health plan shopping and enrollment services through websites, call centers, and in-person help.

Small businesses can use the Small Business Health Options Program (SHOP) Marketplace to provide health insurance for their employees.

When you apply for individual and family coverage through the Marketplace, you'll provide income and household information. You'll find out if you qualify for:

- Premium tax credits and other savings that make insurance more affordable
- Coverage through the Medicaid and Children's Health Insurance Program (CHIP) in your state

Health Insurance Portability and Accountability Act (HIPAA): This is a federal law. It limits the rules a group health plan can place on benefits for pre-existing health problems. It gives people access to quality health care coverage when they switch jobs. This law does not let group health plans charge higher rates because of a person's prior health status. It can also limit rules on some individual health plans. The law also helps protect private health information. It sets national standards for handling private health records.

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. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Health plan categories: Levels of plans in the Health Insurance Marketplace: Bronze, Silver, Gold, and Platinum. Categories (sometimes called "metal levels") are based on how you and your insurance plan split costs. Categories have nothing to do with quality of care. ("Catastrophic" plans are available to some people.)

For each plan category, you'll pay a different percentage of total yearly costs of your care, and your insurance company will pay the rest. Total costs include premiums, deductibles, and out-of-pocket costs like copayments and coinsurance.

Each category may include several types of plans and provider networks, like health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Health Plan Employer Data and Information Set (HEDIS): Part of the process used by the National Committee for Quality Assurance in accrediting managed care organizations. This tool is used by more than 90% of America's health plans to measure performance on important dimensions of care and service.

Health savings account (HSA): This is a part of a health plan. A type of savings account that allows you to set aside money on a pre-tax basis to pay for qualified medical expenses if you have a "high deductible" health insurance plan. Combining a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) allows you to pay for certain medical expenses, like your deductible and copayments, with untaxed dollars. High-deductible plans usually have lower monthly premiums than plans with lower deductibles.

Unlike a Flexible Spending Account (FSA), HSA funds roll over year to year if you don't spend them. You can take the funds with you if you change jobs or leave the work force. Your HSA may also earn interest.

You can start an HSA through your own bank or other financial institution. You can put money into this account. You can use it to pay for covered health care costs. Or you can save money in it for future health care costs. The account grows interest. You can take your account with you if you leave your job. You must be covered by a high-deductible health plan to qualify for an HSA.

High-deductible health plan (HDHP): A plan with a higher deductible than a traditional insurance plan. Usually the monthly premium is lower, but you have to pay more health care costs yourself (your deductible) before the insurance company starts to pay its share. A high deductible plan can be combined with a health savings account or a health reimbursement arrangement. This allows you to pay for certain medical expenses with untaxed dollars.

For 2016, the IRS defines a high deductible health plan as any plan with a deductible of at least $1,300 for an individual or $2,600 for a family.

HIPAA: Also known as the Health Insurance Portability and Accountability Act. This is a federal law. It limits the rules a group health plan can place on benefits for pre-existing health problems. It was passed to give people access to quality health care coverage when they switch jobs. This law does not let group health plans charge higher rates because of a person's prior health status. It can also limit rules on some individual health plans. The law also helps protect private health information. It sets national standards for handling private health records.

HMO: Also known as health maintenance organization. This is a health plan that arranges health care services for its members. In most HMO plans, members choose a primary care physician (PCP). The PCP is from the health plan's provider network. The PCP gives routine care and refers members to network doctors if special care is needed.

Home health care: Health care services a person receives at home.

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

Hospital: This is a place that offers medical care. Patients can stay overnight for care. Or they can be treated and leave the same day. All hospitals must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

Hospital and ER Physician Services: Services performed by a licensed physician at a hospital or hospital's emergency room department.

HSA: See "Health savings account (HSA)."

I

ID card: This is the card members get when they join a health plan. It helps doctors and other health care providers know what coverage a patient has. It shows the member's assigned plan number and plan contact information. Members should show the card at every health care visit.

In-Network: This means we have a contract with that doctor or other health care provider. We negotiate reduced rates with them to help you save money. Your out-of-pocket costs are lower when you stay in network.

There are other benefits to using doctors in network. They will not bill you for the difference between their standard rates and the rate they've agreed to with us. All you have to pay is your coinsurance or copay, along with any deductible. And network doctors will handle any precertification your plan requires.

Indemnity plan: This is a type of health plan. Members can get care from any licensed doctor or hospital. They get the same level of benefits no matter who they see. There is no network. The plan pays a percentage of each covered health care service. These plans often have deductibles, coinsurance and certain benefit maximums. This is also called a traditional plan.

Individual mandate: This is also known as penalty, fine or individual responsibility payment. Beginning in 2014, the Affordable Care Act requires that most people have health insurance for themselves and their dependents. Those that do not may have to pay a penalty. Some people will be exempt from the mandate or the penalty. Others may be given financial help to pay for health insurance.

Individual policy: Policy for people that aren't connected to job-based coverage. Individual health insurance policies are regulated under state law.

Injectable drug: This is a drug that is given with a needle or syringe. The medicine is put under the skin, into a muscle or into a vein. It may start as a powder that is mixed with water.

Inpatient: This is a person who has to stay in the hospital for care for at least one night.

Inpatient care: Health care that you get when you're admitted as an inpatient to a health care facility, like a hospital or skilled nursing facility.

Insurance card: Also known as ID card. This is the card members get when they join a health plan. It helps doctors and other health care providers know what coverage a patient has. It shows the member's assigned plan number and plan contact information. The card should be shown at every health care visit.

J

K

L

Lapse (or lapse in coverage): Anyone who buys an insurance plan pays a premium. You pay this amount every month. If you miss a payment, the insurance company can cancel your coverage. It means you have let your insurance coverage lapse. You have let it end.

Late entrant (also known as late enrollee): There are certain times of the year when workers can choose or change benefits. The main time is called open enrollment. New employees can enroll when they first start. And those who get married or have a baby can make changes in their coverage when this change in their life occurs.

Late entrants are:

- New employees who do not sign up within 31 days of being hired. They later choose coverage during open enrollment.
- Employees who do not choose or change coverage within 31 days of getting married or having a baby. They later do so during open enrollment.

Length of stay (LOS): This is the number of days a patient stays in the hospital for treatment. Days are counted in a row.

Lifetime maximum: This is the total dollar amount of benefits you can receive. It can also be the total number of services you can receive. These totals are limits for a lifetime, not just for a plan year. Plans subject to federal health care reform can only have lifetime dollar maximums on non-essential benefits.

Limitations: These are restrictions that health plans place on coverage. They say what your plan does not cover.

M

Mail order drugs: Also known as maintenance medications. These are prescription drugs that people take on a regular basis. These drugs help treat chronic conditions. These drugs include ones for asthma, diabetes, high blood pressure and other health conditions. Buying them through a mail-order pharmacy can save money.

Mail order pharmacy: People can get prescription drugs through the mail with this. It is a service that health plans often offer. Members can save time and money using it by getting a three-month supply all at once. NoviXus is the name of FirstCare's mail order pharmacy.

Maintenance medications: These are prescription drugs that people take on a regular basis. These drugs help treat chronic conditions. These drugs include ones for asthma, diabetes, high blood pressure and other health conditions. Buying them through a mail-order pharmacy can save money.

Managed care: This is a type of health plan. It is an agreement signed with doctors and hospitals to form a network. Members may get a higher level of benefits if they use doctors or hospitals in this network. Costs are often higher when people go out of the network for care. The plan may also require preapproval of some services.

Managed care company: This is a health insurance company. See also "Managed care."

Managed Care Organization (MCO): Any organization or healthcare plan that takes a managed care approach to the delivery of services.

Mandated benefits: These are the benefits that health care plans must provide. State or federal law requires them.

MA plan: This is a type of Medicare Advantage plan. It does not cover prescription drugs.

MA-PD plan: This is a type of Medicare Advantage plan. It covers prescription drugs.

Marketplace: See “Health insurance marketplace.”

Maximum benefit amount: This is an amount of money that is paid to people through a disability plan or life insurance policy. It is the most that they can receive in one period. That could mean every week, every month, or once a year. The plan spells out how often this amount is paid.

Medicaid: Insurance program that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Many states have expanded their Medicaid programs to cover all people below certain income levels.

Whether you qualify for Medicaid coverage depends partly on whether your state has expanded its program. Medicaid benefits, and program names, vary somewhat between states.

You can apply anytime. If you qualify, your coverage can begin immediately, any time of year.

Medical emergency: Also known as emergency. This is a serious illness or injury. It comes on suddenly. It is something that needs immediate medical care. If a person does not get care quickly, death or serious health problems may occur.

Medical underwriting: A process used by insurance companies to try to figure out your health status when you're applying for health insurance coverage to determine whether to offer you coverage, at what price, and with what exclusions or limits.

Medically necessary: Also known as necessary. Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

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

Medicare Advantage plan: See “Medicare Part C.”

Medicare limiting charge: This applies to a health care provider. The provider does not participate in Medicare. There is a limit on how much the provider can charge for a service covered by Medicare. The limit is 15% more than the amount Medicare allows for the service.

Medicare Part A: This is part of the original Medicare plan. It is managed by the federal government. It covers some, but not all, expenses for:

- Inpatient care at a hospital
- Medical care at a skilled nursing facility
- Hospice care
- Home health care

The plan has limits. People also must pay deductibles, copays and other costs.
Medicare Part B: This is part of the original Medicare plan managed by the federal government. People sign up for this plan. They usually pay a monthly premium for the plan. It covers:

- Necessary services from doctors
- Outpatient care from a hospital

It also pays some costs for some:

- Physical therapy
- Occupational therapy
- Home health care

Medicare Part C: This is a Medicare program offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Part D: This is an optional Medicare plan 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.

Medicare prescription drug plan: This is an optional Medicare plan. It is separate from a Medicare health plan. It provides coverage for some prescription drugs. It is offered through a private company. Sometimes it is called a PDP.

Medication: This is a drug a person takes. It can be a prescription drug or an over-the-counter drug.

Mental disorder: This is a problem with brain function. It affects the way people see themselves and the world they live in. It may also affect how they act.

Examples include depression, post-traumatic stress and schizophrenia. These types of conditions are not always easy to recognize. They do not show up on blood tests or X-rays.

Mental Health Services: Care or treatment for emotional or behavioral conditions by a licensed physician or mental health professional.

Metal Plans: Four levels of health insurance plans, Bronze, Silver, Gold and Platinum, offered by the Marketplace with similar health benefits, but different out-of-pocket costs and premiums.

Methodology: This is a method or process that is followed.

N

National Committee for Quality Assurance (NCQA): This is an independent, nonprofit group. It is also known as the NCQA. The NCQA has an official recognition process. It measures how well a health plan:

- Manages its care delivery system
- Improves health care for members

NCQA: Also known as National Committee for Quality Assurance. This is an independent, nonprofit group. The NCQA has an official recognition process. It measures how well a health plan:

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Necessary: Health plans usually pay only for care that is necessary. They decide this by using medical standards or research that states what care is most effective. Care can mean health services or supplies. This also is called medically necessary, medically necessary services or medical necessity.

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

Neonatal Intensive Care Unit (NICU): A specially equipped hospital unit where premature and critically ill newborns receive intensive medical care.

Non-Preferred Brand Name Drugs: Brand name prescription drugs that may have a generic equivalent or similar drug available, but generally cost more to purchase.

Nonparticipating provider: This is a health care provider who does not have a contract with a health plan. People might pay more when they visit this kind of doctor, hospital or other health care professional. This may also be referred to as out of network or nonpreferred.

Nonprescription: This means a person can buy a drug without a doctor's prescription.

O

Obamacare: Also known as the Affordable Care Act. It's an informal name sometimes used to refer to the health coverage plans available through the Health Insurance Marketplace.

Obamacare Summary:

- Signed into law March 23, 2010 by President Obama, which is where the term "Obamacare" comes from
- The Open Enrollment Period for 2016 health insurance is over
- The Health Insurance Marketplace helps you find and enroll in a plan

Occupational therapy: People can lose some skills because of an accident or illness. These skills include walking, eating, drinking, dressing and bathing. This treatment helps restore the skills.

Office of the Inspector General (OIG): Part of the U.S. Department of Health and Human Services (HHS), the Office of Inspector General's mission is to protect the integrity of HHS programs as well as the health and welfare of program beneficiaries. OIG's activities include fighting waste, fraud, and abuse in Medicare, Medicaid and more than 300 other HHS programs.

Open enrollment period: The yearly period when people can enroll in a health insurance plan. Outside the Open Enrollment Period, you generally can enroll in a health insurance plan only if you qualify for a Special Enrollment Period (SEP). You qualify if you have certain life events, like getting married, having a baby, or losing other health coverage.

- Job-based plans may have different Open Enrollment Periods. Check with your employer.
- You can apply and enroll in Medicaid or the Children's Health Insurance Program (CHIP) any time of year.

Open formulary: Some prescription benefits plans cover all eligible prescription drugs. This means they have an open formulary. In these plans, people might have lower copays for drugs on the preferred drug list. They might have higher copays for drugs that are not on this list.

Optimum: This means most favorable or best.

Oral: This means by mouth.

Oral and maxillofacial surgeon: This dental surgeon treats in and around the inside of the mouth and jaws.

Original Medicare plan: Also known as Medicare Part A. This is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Out of network: If you choose a doctor or other health care provider who is out of network, your plan may pay some of that doctor's bill. But it will pay less than if you get care from a doctor in our network. You will pay more money if you decide to use a doctor that is not in our network.

Check your plan documents for more details: Your health plan documents will tell you how we pay for out-of-network care. Or call Member Services at the phone number listed on your ID card.

Out-of-pocket costs: Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Out-of-pocket maximum: This is a limit on the costs a health plan member must pay for covered services. The limit can be yearly or a dollar amount.

Outcomes: Measures of medical care quality in which the standard of judgment is the attainment of a specified result or outcome.

Outpatient care: This is care a person gets in a clinic, emergency room, hospital or surgery center. The person goes home after the procedure. There is no overnight stay.

Outpatient procedure: Some procedures can be done in a hospital, surgery center or doctor's office. The person goes home after the procedure. There is no overnight stay. This is also called ambulatory surgery.

Over-the-counter drugs: These are drugs that can be bought without a prescription. They are not covered under most prescription benefits plans.

P

Palliative care: This is care given for immediate pain relief. It is not a final treatment for a condition.

Partial day treatment: This is a behavioral health program. It provides treatment for mental health or substance abuse issues. It is offered during the day or at night. No overnight stay is needed.

Participating pharmacy: This is a pharmacy that has a contract with a health plan. It fills covered prescriptions for plan members. Members might pay less for their prescriptions at this type of pharmacy.

Participating provider: This is a doctor, hospital or other health care provider. The provider signs a contract with a health plan. The provider is part of the plan's network for covered services. People may pay less when they visit this type of provider.

PCP: Also known as primary care physician. This is a doctor who is part of a health plan's network. This doctor is a patient's main contact for care. PCPs give referrals for other care. They coordinate care their patients get from specialists or other care facilities. In some health plans, a person must choose a PCP to coordinate care.

Pending claim: This is a medical claim that has not yet been approved or denied.

Personal health record: This is a record of a person's health information. It can include claims and other health history. It is stored online and viewed on a computer. A health plan can add to it. It might add medical claims received and doctor visit information. People can also add their own information to it. They might add information on family health or eating habits.

Pharmacy: A pharmacy is a drug store.

Pharmacy and therapeutics committee: This is a group of health care professionals. Doctors, pharmacists and others are on it. The group advises a health plan company on safe and effective drug use. It also helps the plan create a formulary.

Pharmacy Benefit Manager (PBM): A third-party administrator responsible for prescription drug programs.

Pharmacy copay: This is a person's share for covered prescription drugs. It is paid to a participating pharmacy. It is a set dollar amount.

Physical therapy: This is care given to help improve part of the body. It helps ease pain and promote healing. It can also help prevent disability. It is used to limit the effects of disease. It is also used after illness, injury or surgery.

Physician: This is a medical doctor. A licensed doctor, such as Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatry (DPM), Doctor of Chiropractic (DC), Doctor of Dental Surgery or Dental Medicine (DDS or DMD) or Doctor of Optometry (OD).

Placebo: This is a substance that has no medicine it. It is also called a sugar pill. It can be given to help people expect to feel better. It is usually used during tests to find out how potential new drugs and treatments will work.

Plan documents: A plan sponsor gets important papers from a health plan. These are plan documents. They describe the details of coverage. They include the:

- Group agreement
- Group policy
- Certificate or evidence of coverage or certificate of insurance
- Summary of coverage or benefits

Plan exclusions and limitations: These are legal conditions. They apply to health plans. They list specifically what is and what is not covered by the plan.

Plan maximum: This is a limit on the dollar amount of benefits a health plan will play.

Plan sponsor: This is a group that sets up and manages a health plan or group insurance plan. It can be an employer. It can also be a labor union, government agency or nonprofit group.

Plan type: A category of health care plans, such as PPO, HMO and EPO.

Platinum health plan: One of 4 categories (or “metal levels”) of Health Insurance Marketplace plans. Platinum plans usually have the highest monthly premiums of any plan category but pay the most when you get medical care. They may work well if you expect to use a great deal of health care and would rather pay a higher premium and know nearly all other costs are covered. See also “Health plan categories.”

Point of service (POS): A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan’s network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

Policy: Also known as a contract. This is a legal agreement. It is between a customer (an individual or group) and an insurance plan. It lists all details of the plan’s coverage.

Policy holder: This is a person who has a contract with an insurance company.

Portability: This is a legal right of an insured person. The person gets to keep group insurance as an individual policy. People don't have to prove they are in good health to keep the policy.

POS: Also known as point of service. This is a type of health plan. It lets members see participating providers. They can also see nonparticipating providers. In many POS plans, members who use referrals and see a Primary care physician (PCP) get more coverage. They may pay less for care. Members can get care from a provider who is not a PCP. They might pay more for care.

PPO: Also known as Preferred Provider Organization. A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Preauthorization or precertification: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Pre-existing condition: A health problem you had before the date that new health coverage starts

Preferred Brand Name Drugs: A category of brand name prescription drugs that are less expensive than non-preferred brand name drugs.

Preferred care provider: Also known as a participating provider. A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Preferred drug list: Also known as formulary. This is a list of prescription drugs the health plan covers. It can include drugs that are brand name and generic. Drugs on this list may cost less than drugs not on the list. How much a plan covers may vary from drug to drug. An open formulary provides a greater choice of covered drugs. It is also called a preferred drug list.

Preferred provider organization (PPO): This is a type of health benefits plan. Members can choose any doctor. They do not have to name a primary care physician. No referrals are needed. Members who go to network providers usually get more coverage. They may pay less for services.

Premium: This is the amount paid to a health plan company for coverage. A person can pay it directly. Sometimes a person has a health plan with an employer. Then this cost might be shared between the person and the employer.

Prescription: A doctor's order for a drug is a prescription. It is usually written. If it is a verbal order, it must be put in writing by the pharmacy.

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

Prescription drug plan (PDP): This is any benefits plan or insurance plan that helps pay for prescription drugs.

Present on Admission (POA): A condition that was present when the patient was admitted to a hospital.

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

Primary care physician (PCP): A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Prior authorization: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Prior creditable coverage: This term means types of health coverage a person has had. People sometimes need to prove they have had this so they can be fully covered by a new plan. Some examples of acceptable types are:

- Group or individual coverage
- Medicare
- Medicaid
- A public health plan (any plan established by a state, the government of the United States, or any subdivision of a state or of the government of the United States, or a foreign country)
- Any health benefits plan under Section 5(e) of the Peace Corps Act
- The State Children's Health Insurance Program (S-CHIP)

Private fee-for-service plan: This is a type of Medicare Advantage plan. It is offered through a private health plan company. A person pays a premium for medical coverage. Then, the person can go to any doctor or hospital that:

- Is approved by Medicare
- Accepts the plan's payment and other terms

Progressive: In health care, this refers to an illness or condition that gets worse over time.

Protected Health Information (PHI): Protected health information is any information about health status, provision of healthcare, or payment for healthcare that can be linked to a specific individual. This is interpreted rather broadly and includes any part of a patient's medical record or payment history.

Provider: This term is used often by health plans. It means a licensed person or place that delivers health care services. Some examples are doctors, dentists, hospitals and more.

Provider network: Also known as network. A network is a group of health care providers. It includes doctors, dentists and hospitals. The health care providers in the network sign a contract with a health plan to provide services. Usually, the network provides services at a special rate. With some health plans, people get more coverage when they get care in the network.

Provider Owned: This term is used when hospitals and health systems develop their own health plan.

Q

Qualified medical expenses (QMEs): Also known as eligible medical expenses, these are costs paid for health care that people can deduct from their taxes. To do so, they must not have received payment for the expense through insurance.

Qualifying life event (QLE): A change in your situation – like getting married, having a baby, or losing health coverage – that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the yearly Open Enrollment Period. There are 4 basic types of qualifying life events:

- Loss of health coverage
- Changes in household
- Changes in residence
- Other qualifying events

R

Radiation therapy: This is a treatment used to fight cancer. High-energy rays damage cancer cells so they stop growing.

Reasonable charge: A limit on the amount your health plan will pay. Also called usual, customary and reasonable (UCR), customary and reasonable, or prevailing charge. The limit is based on data we receive. The data is based on what doctors charge for the health care service.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Referral: A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Rehabilitative/Rehabilitation services: Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Reimbursement: This is money you get back from your health plan for covered costs you paid to your doctor.

Renewal: This is when an insurance policy continues, but with changed terms, like new rates.

Respite care: This is care that gives families a short break from the duties of constant care.

Retiree: This is an employee who has retired from working. To retire, an employee must meet the employer's rules for minimum age and years of service.

Rider: A rider is an amendment to an insurance policy. Some riders will add coverage (for example, if you buy a maternity rider to add coverage for pregnancy to your policy). In most states today, an exclusionary rider is an amendment permitted in individual health insurance policies that permanently excludes coverage for a health condition, body part, or body system. Starting in September 2010, under the Affordable Care Act, exclusionary riders cannot be applied to coverage for children. Starting in 2014, no exclusionary riders will be permitted in any health insurance.

Risk: This is the chance or likelihood of loss.

Rx: This is a common symbol. It means prescription or pharmacy.

S

Schedule of benefits and exclusions: This list states what a policy does and does not cover.

Second opinion: This is an opinion you get from a second doctor. You get this after you receive an opinion from the first doctor you went to see. It gives you a chance to compare the two opinions. Then you can decide how you want to treat your problem.

Self-funded plan: Also known as a self-insured plan. This is a type of plan in which the employer takes on most, or all, of the costs of benefit claims. The benefit company manages the payments. But the employer is the one who pays the claims. These plans are often more flexible for the employer. That is because the employer is often not subject to state law requirements.

Self-insured employer: This is an employer who pays benefit claims for employees. The employer takes on most, or all, of the risk of the costs of benefit claims. The benefit company manages those payments.

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 can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.

SEP: Also known as a Special Enrollment Period. It's a time outside the yearly Open Enrollment Period when you can sign up for health insurance. You qualify for a Special Enrollment Period if you've had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child.

- If you qualify for an SEP, you usually have up to 60 days following the event to enroll in a plan. If you miss that window, you have to wait until the next Open Enrollment Period to apply.
- You can enroll in Medicaid and the Children's Health Insurance Plan (CHIP) any time of year, whether you qualify for a Special Enrollment Period or not.
- Job-based plans must provide a special enrollment period of at least 30 days.

Service area: A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may end your coverage if you move out of the plan's service area.

Sickness: This is a condition for which you would need medical care.

Silver health plan: One of 4 categories of Health Insurance Marketplace plans (sometimes called "metal levels"). Silver plans fall about in the middle: You pay moderate monthly premiums and moderate costs when you need care. Important: If you qualify for "cost sharing reductions" (or "extra savings") you can save a lot of money on deductibles, copayments, and coinsurance when you get care — but only if you pick a Silver plan. Silver plans are the most common choice of Marketplace shoppers. See also "Health plan categories."

Skilled nursing facility (SNF): Skilled nursing care and rehabilitation services provided on a continuous, daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Small business health insurance: This is health insurance for companies that have 2 to 50 employees. These plans help employers save on their taxes. And they help employees save on their premiums.

Special Enrollment Period (SEP): A time outside the yearly Open Enrollment Period when you can sign up for health insurance. You qualify for a Special Enrollment Period if you've had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child.

- If you qualify for an SEP, you usually have up to 60 days following the event to enroll in a plan. If you miss that window, you have to wait until the next Open Enrollment Period to apply.
- You can enroll in Medicaid and the Children's Health Insurance Plan (CHIP) any time of year, whether you qualify for a Special Enrollment Period or not.
- Job-based plans must provide a special enrollment period of at least 30 days.

Special Needs Plan (SNP): This is a state-certified program that provides services to a specific group with special needs.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Specialty drug: An FDA-approved prescription drug designated by the health plan because it requires special handling, storage, training, distribution requirements and/or management of therapy. They can be provider administered or self-administered.

Speech-language therapy: This is treatment to improve a person's speech or language skills. The problem could have started from birth. But it could also have been from a disease, an earlier medical treatment or a time when the person got hurt.

Staff model: This is a type of HMO plan. Doctors are employees of the HMO. This is different from an independent practice association (IPA) HMO. In an IPA-model HMO, the doctors are not employees of the HMO.

STAR – STAR+PLUS: A Texas Medicaid managed care program for people who have disabilities or are age 65 or older.

State insurance department: A state agency that regulates insurance and can provide information about health coverage in its state.

State-mandated benefits: These are benefits a state requires in a policy. If the benefit is not in the policy, it cannot be sold in the state.

STD: Also known as short-term disability. This pays part of a worker's pay while out of work. The person must be out of work for a short time with an illness or injury that is not related to work.

Step therapy: This is a way that a health plan controls drug costs. It means a person must try certain drugs before the plan will pay for a particular brand-name drug. The first drugs are often generic and cost less.

Stop-loss coverage: This protects employers who take on most of the risk of a health plan. An employer can buy this to avoid having to pay for large health claims. If health care costs go over the amount listed in the contract, the plan will pay the rest.

Subscriber: This is a person who signs up for a health plan. If it's a family health plan, the subscriber add people to it as dependents. Those people must be eligible to join. Some health plans also use the word enrollee for this term.

Subsidy or Premium Tax Credit: Assistance from the government to help pay for the monthly insurance bill for those that qualify. The tax credit depends on taxable household income, family size and ages and location of residence. It does not pay for out-of-pocket health care costs, but financial assistance may be available to those who qualify.

Summary of Benefits and Coverage (SBC): An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits, and other features that may be important to you. You'll get the "Summary of Benefits and Coverage" (SBC) when you shop for coverage on your own or through your job, renew or change coverage, or request an SBC from the health insurance company.

Supplemental Security Income (SSI): A federally supported and administered benefit program for eligible individuals or couples who are 65 years of age and older, or who are certified blind or disabled (at any age).

T

Telemedicine: This allows doctors to treat patients without an office visit. They use video, telephones or e-mail to talk. This can help improve care. And patients in remote places can get help from doctors and specialists who are far away.

Tertiary care: This is specialized medical care. It involves complex procedures. People usually need this care for a long time. Specialists in state-of-the-art medical centers give the care.

Texas Association of Community Health Plans (TACHP): This is a consortium of 11 health plans in communities across Texas that provide and improve health care for Texans.

Traditional plan: Also known as an indemnity plan. This is a type of health plan. Members can get care from any licensed doctor or hospital. They get the same level of benefits no matter who they see. There is no network. The plan pays a percentage of each covered health care service. These plans often have deductibles, coinsurance and certain benefit maximums.

U

UCR: Also known as usual, customary and reasonable. 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 sometimes is used to determine the allowed amount.

Uncovered services: These are also called exclusions. They are specific conditions or services that are not covered under a health plan. They are listed in the plan documents. Check to see what is not covered before enrolling in a plan. Ask the plan or your employer for a copy of the plan documents.

Underwriting: This process helps assess the costs of insuring potential members. It is used to decide who is eligible for coverage. Medical questions may be asked. A health exam may be required. Rate level and premiums are based on results.

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

Urgent care centers: These centers can treat urgent, but non-life-threatening medical issues. A few examples are sprains, fractures and minor burns. Urgent care clinics are a convenient option to the emergency room. They're staffed with nurses and doctors. You wait less. You don't need an appointment. Many are open seven days a week. And you usually pay less.

If you have a medical issue that threatens your life, always visit your local emergency room first.

Usual, customary and reasonable (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 sometimes is used to determine the allowed amount.

Utilization Management (UM): A systematic means for reviewing and controlling patients' use of medical care services and providers' use of medical care resources.

Utilization Review (UR): The evaluation of the necessity, appropriateness, and efficacy of the use of medical services, procedures, and facilities. UR can be performed by a utilization review committee, peer review organization, peer review group, public agency, provider, or managed care plan.

V

W

Walk-in clinic: This is a health care center. You find it in many supermarkets and pharmacies. A clinic treats minor illnesses and injuries. It also offers health screenings and vaccines. The clinic is often open evenings, weekends and holidays. When you can't see your regular doctor, a walk-in clinic can be a good option.

Well-baby/Well-child care: Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments.

Well woman care: This is the regular care a woman needs. It includes checkups with the Obstetrician/Gynecologist and regular pregnancy care.

Wellness programs: A program intended to improve and promote health and fitness that's usually offered through the work place, 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 preventative health screenings.

Workers' compensation: An insurance plan that employers are required to have to cover employees who get sick or injured on the job.

X

X-ray: This is a picture that can show bones and other internal parts of the body. It is used to help diagnose certain conditions

Y

Z