Understanding Health Insurance and How to Use It

Health insurance helps us get the medical care we need without having to overspend. However, it's not always easy to understand how health insurance works and how to use it.

This guide will help you understand the intricacies of health insurance and help you save money by avoiding unexpected and costly bills, and most importantly, help you get the care that you need.

What is health insurance?

Health insurance helps you pay for doctor visits and hospital costs.

Health insurance protects you from high medical costs, resulting from doctor visits, hospital stays, and certain medications. By learning how your insurance works, you will be able to:

- **Pay less out of your own pocke**t: Your insurance might cover most of the cost, so you don't have to pay as much.
- **Avoid surprise bills:** Know what is and isn't covered so you will be able to plan ahead for any medical expenses.

How does understanding health insurance help you?

First, learn the basic terms in your health insurance plan.

Health insurance has some important words you need to know, such as "deductible" and "co-pay." Learning these words can help you:

- **Understand your costs:** Knowing what each term means makes it easier to know how much you'll pay.
- **Avoid confusion:** Knowing what is included in your insurance helps you avoid surprises when you get a bill.

Health insurance will help you save money.

Health insurance often works with certain doctors and hospitals called a "network." Going to in-network providers costs less. Understanding this can help you:

- **Save on co-payments:** By going to in-network doctors, you won't have to pay as much out of pocket for each visit.
- **Avoid extra charges:** Choosing an out-of-network provider could cost more, or your insurance might not cover your visit.

Preventive care is often covered.

Most health insurance plans cover preventive care, such as vaccines, check-ups, and health screenings — at little or no cost. By understanding what is covered, these benefits can:

- **Keep you healthy:** Regular check-ups can help you catch health issues early, making them easier to treat.
- **Prevent bigger problems:** By staying on top of your health, you'll be less likely to need expensive treatments later.

You could benefit from additional health benefits.

Many health insurance plans offer extra benefits, such as mental health support, wellness programs, or telehealth (video calls with a doctor). Using these extras can help you:

- **Take care of your health in new ways:** You might find programs for exercise or nutrition that keep you healthy or discover the convenience of visiting with the doctor in the comfort of your own home.
- **Spend less on extra care:** These services are often free or discounted, so they can help you save money.

Billing will be easier.

Knowing what's included in your insurance plan makes it easier to manage any bills you get. Being informed can help you:

- **Spot billing mistakes:** By knowing what's covered and what isn't, you will easily be able to check that bills are correct.
- **Get claims paid quickly:** Knowing how claims work will make it easier to get the insurance company to pay their portion, so you aren't stuck paying for the entire bill.

You will be prepared for major health events.

If you or someone in your family undergoes a major medical event, such as a surgery or the birth of a baby, understanding your insurance will help you to be prepared so you can:

- **Get the right care:** Understanding what is covered will make it easier to plan for care before, during, and after an event.
- **Manage follow-up care costs:** Knowing what to expect will make it easier to get the care you need for recovery without having extra expenses.

In Summary

Learning about your health insurance plan will empower you to take better care of your health and finances and help to ensure that you get the care you need, while avoiding overpayments and preventing unexpected bills. Reaching out to your insurance provider with any questions is also important. By following this guide and learning more about health insurance, you will make a significant difference to not only your health and well-being, but to your finances.

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Open Enrollment Tips

It's important to enroll in a health insurance plan every year. It's also important to choose an insurance plan that best meets the needs of you and your family. Whether you decide to obtain your coverage through Medicaid, Medicare, or your employer, reviewing the options can be stressful and overwhelming.

Here are some steps to help you simplify the decision-making process and lessen your stress as you select a plan for you and your family.

Step 1. Learn Commonly-Used Health Coverage Terms

Health insurance plans typically include several important terms and provisions intended to describe types of plans, coverage, costs, benefits, limitations and exclusions. A few examples of these key terms are listed below:

- **Essential Health Benefits:** A set of healthcare service categories that must be covered by certain plans. Defined by the Affordable Care Act, essential health benefits include, but are not limited to, the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services.
- **Coordination of Benefits:** A way to figure out who pays first when two or more health insurance plans are responsible for paying the same medical claim.
- **Provider Network:** A list of doctors, other health care providers, and hospitals that a plan contracts with to provide medical care to its members.
- **Preferred Drug List (PDL):** A PDL is a list of medications that an insurance plan covers at lower costs. A PDL is part of the plan's formulary, which is a broader list of all covered medications. If a medication is not on the PDL, you may have to pay more or get an exception approved by your insurer to obtain the drug.

Step 2. Assess Your Health Care Needs

Consider what kind of care you and your family need.

- **Doctor visits per year:** If you or your family have multiple doctors and/or specialists and usually make frequent visits to the doctor, look into a plan with a low copay.
- **Use of prescription medications:** How many prescription medications does your family purchase on a regular basis? It's also important to know which medications your family uses and if these medications are covered under the plan you choose. Some plans cover more medications than others.
- **Specialized care:** Some conditions require specialized care and/or treatment. It is important to know if this applies to anyone in your family who will be covered under your health plan and which plan will cover these needs.

Step 3. Compare the Costs

When you compare plans, it is important to understand how much of the cost you are responsible for versus what the plan will pay.

- **Premium:** This is the amount you pay each month to keep your insurance. Even if you don't visit the doctor during a particular month, you will still be required to pay. Higher premium plans often have lower deductibles.

- **Deductible:** This is the amount you must pay each year before the insurance begins to lower your costs. A higher deductible usually means a lower monthly premium. If you're healthy and don't need much care, a high-deductible plan may save you money.
- **Copayment (copay):** This is a fee you may be required to pay each time you visit your doctor or pick up a prescription. In some plans, a copay may also be required for health-related testing, such as bloodwork or X-rays.
- **Out-of-pocket maximum:** If you have a lot of medical costs in a year, this limit will protect you from having to pay too much.
- **Coinsurance:** This is the percentage of a medical bill you will have to pay after you've reached your deductible and before you have reached your out-of-pocket maximum.

Be sure to compare the total costs for plans you're considering, not just the monthly premiums.

Step 4. Review the Provider Network

- **In-network:** Each health insurance plan has a provider network that lists doctors, hospitals, clinics, pharmacies, and other care facilities that have contracted with the health plan and are considered "in-network," meaning that these providers accept that type of insurance and that your cost to see the provider will be less. If you already have a doctor you like, make sure they're included in the plan's network.
- **Out-of-network:** If you receive care or services from a provider not included in the health insurance plan's network, they are referred to as an "out-of-network" provider. Typically, the copay and coinsurance you will owe to this provider will be higher than an in-network provider. **It is important to note that many health insurance plans do not offer coverage for ANY out-of-network services, which means you will be responsible for 100% of those costs and they will not apply to your out of pocket maximum.**

Step 5. Review the Plan's Summary of Benefits

Each health insurance plan covers different types of care. Look for plans that cover the services you need, such as:

- **Doctor visits and checkups**
- **Prescription medications**
- **Emergency care**
- **Specialist care**
- **Mental health services**

Step 6. Review Extra Benefits (if offered)

Some plans offer extra benefits that may be helpful, such as:

- **Telehealth visits** (seeing a doctor online)
- **Vision or dental care** (for glasses, eye exams, or dental checkups)
- **Wellness programs** (gym discounts or health classes)

Step 7. Use a Checklist to Compare Plans

Make a list of the things you care about most when it comes to your health care insurance plan, whether it's low monthly costs, coverage for medications, or a large network of doctors. Once you've made your list, review each plan and check off the things it offers that mean the most to you.

Step 8. Ask for Help if You Need it

If you are still unsure about which plan to choose, there are resources available to assist you, depending on where you plan to obtain your coverage. Many states offer help to consumers through Consumer Assistance Programs (CAPs). These programs are designed to assist consumers who are experiencing problems with their health insurance or who are looking to learn more about their health care options. CAPs offer direct assistance by phone, direct mail, email, and in person by providing walk-in locations to help consumers learn how to obtain or use their insurance effectively. For more information visit: Consumer Assistance.

Other options for assistance with your health insurance include reaching out to your human resource department if you are getting coverage through your employer, contacting your health insurance provider directly, and communicating with your local or national patient advocacy organizations.

Step 9. Take Your Time

Again, it is critical that you choose a health care insurance plan within the limited open enrollment period, it's also important for you to take time to thoroughly read through the different health insurance plan options and to choose the one that meets the specific needs of both you and your family.

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Reading Your Explanation of Benefits (EOB)

What is an explanation of benefits?

You may qualify for IHS services if you are:

- An explanation of benefits (EOB) shows you the total charges for your visit.
- An explanation of benefits is **not** a bill.

It helps you understand how much your health plan is paying toward a bill for medical services you received and how much you will have to pay when you receive a bill from your provider.

What information is included in an explanation of benefits?

General information about you and your health plan

The explanation of benefits includes information about:

- **You** (the patient)
- **Your health plan**
- **Who provided your care, and when it was provided**
- **A reference number or claim number**
- **Your health plan's phone number**

Call your health plan if you have questions about what is listed in the EOB.

Details about your claim(s)

The explanation of benefits gives you details about your care, such as:

- **The date of service**
- **A service description,** explaining what service you had, such as a medical visit, lab test, or screening.

Information about your bill

The explanation of benefits lists the cost of your care, and how much your health insurance company will pay.

- **Provider charges** is the amount your provider bills for your visit.
- **Allowed charges** is the amount your provider will be paid. This may not be the same as the Provider Charges.
- **Paid by insurer** is the amount your health plan will pay to your provider.
- **What you owe,** or **patient balance,** is the amount you owe after your insurer has paid everything else.

Please note, the patient balance as shown on the EOB, represents what you owe per your policy, which you may have already paid some or all of as a copay at the time of your appointment. Payments made by you are not shown on the EOB.

The bill you receive from your provider should not be higher than the Patient Balance listed in the EOB. If it is, talk to your provider.

If your bill details services you do not think were received, contact your health plan.

Remark code

A remark code is a note from the health plan that explains more about the costs, charges, and amounts paid for your visit.

The code is usually two or three letters and numbers. Check the bottom of the explanation of benefits for a description of each code.

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What is a Prior Authorization?

Sometimes payers (such as an insurance company, Medicaid, or Medicare) require you or your health care provider to obtain approval before a specific medical service, procedure, or medication is provided.

Insurance companies are required to follow specific guidelines when reviewing a request for medications or health care services which help to make sure everyone is treated the same. The prior authorization process can be utilized by insurance companies as a cost-control measure to ensure that the treatments and services provided to their members are necessary, appropriate, cost-effective, and fair.

Key parts of prior authorization include:

- **Approval process:** Your health care provider submits a request to the insurance company explaining why the proposed treatment or service is necessary. The insurance company then reviews this request to determine if it meets their criteria for coverage.
- **Medical necessity:** The insurance company assesses whether the requested service or medication is medically necessary based on their guidelines and policies. They may require documentation, such as medical records or test results, to support the request.
- **Coverage determination:** If the insurance company approves the prior authorization request, they agree to cover the service or medication, and it will be paid for according to the terms of your health plan. If the request is denied, you may be responsible for the full cost if you choose to move forward with the service or medication.
- **Time:** Prior authorization requests can take time to process, so it is important to plan. Urgent requests may be expedited; however, routine requests can take several days or weeks. A comprehensive list of state-specific prior authorization response timelines published by the American Medical Association (AMA), can be found here.
- **Appeals:** If a prior authorization request is denied you have the right to appeal the decision. The appeals process allows you to provide additional information or clarification to support your case. You will receive a letter with your denial. Follow the instructions carefully on how to appeal.*

**You will need to work with your health care provider to appeal.*

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What are Copay Maximizer Programs?

Some people take expensive medicines to stay healthy. Drug companies often help by giving copay assistance, which is money that helps patients pay for their medicine.

Insurance companies and pharmacy benefit managers (PBMs) use Copay Maximizer Programs (CMPs) to ensure that they get the maximum benefits provided by the drug company. These programs spread out the copay assistance over time, decreasing the cost of a patient's medicine/prescription each month.

Unlike some other programs, such as Accumulator Adjustment Programs, or AAPs, CMPs don't require patients to pay heavy or hefty costs later in the year. Instead, the patient continues to pay little or nothing for their medicine.

How do they work?

Copay maximizer programs work by spreading out drug manufacturer copay assistance over the entire year, preventing it from counting toward a patient's deductible or out-of-pocket maximum. Here's how they function:

Full use of copay assistance: Instead of applying manufacturer assistance to a patient's deductible, insurers treat it as a separate benefit, ensuring they get the maximum amount offered by the drug company

Reduce monthly costs for patients: Patients may pay less each month because the assistance is divided across the year, making medications seem more affordable in the short term.

Delays progress on deductibles and maximums: Since the copay assistance doesn't count toward what patients must pay before insurance kicks in, they may end up paying more later when the assistance runs out.

Encourages use of certain medications: Insurers and pharmacy benefit managers (PBMs) often direct patients toward specific drugs that work with these programs, influencing medication choices.

Example

Sarah takes a medicine that costs $1,000 per month. The drug company gives $12,000 per year to help.

- Without an CMP – The drug company's money might be used up in a few months, and Sarah would have to pay full price later in the year.
- With an CMP – The insurance company spreads out the money over the whole year, so Sarah keeps paying little or nothing for her medicine.

Why do insurance companies like copay maximizer programs?

Insurance companies favor CMPs because they can or are able to maximize savings while shifting more costs to drug manufacturers. Here are other reasons why they prefer these programs:

- **Reduce insurance payout** – CMPs ensure that copay assistance from drug manufacturers covers a larger portion of patients' out-of-pocket costs, reducing what the insurer has to pay.
- **Lower overall cost** – By spreading out manufacturer assistance over time, insurers can minimize their own spending while still appearing to offer coverage.
- **Encourage alternative medication** – CMPs can push patients toward lower-cost alternatives, such as generics or different medications covered under the insurer's preferred drug list.
- **Avoid out-of pocket maximum** – Since manufacturer copay assistance doesn't count toward a patient's deductible or out-of-pocket maximum under CMPs, patients may end up paying more over time, leading to higher cost-sharing.
- **Increase negotiating leverage** – By implementing CMPs, insurers and PBMs can pressure drug manufacturers into offering larger rebates and discounts.

How do CMPs affect patients?

CMPs can be both a benefit and a detriment to patients on high-cost prescriptions.

Possible benefits:

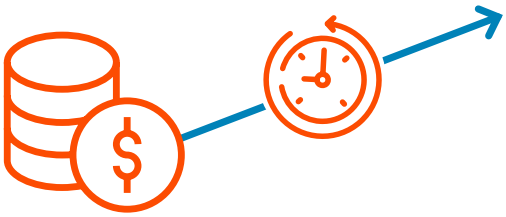
- **Lower monthly costs:** CMPs spread out the help from drug companies, so patients pay less each month.
- **Easier to afford at first:** Since the help lasts all year, patients don't have to pay a big amount all at once.

Major drawbacks:

- **Requires patient to enroll in drug manufacturer assistance program:** Assistance Programs have eligibility requirements and not everyone will qualify. Not all medications are included in the CMP.
- **Delayed progress toward deductibles:** Patients may end up paying more before their insurance fully kicks in, as the manufacturer's contributions don't reduce their required spending.
- **Limited choice in medications:** CMPs may push patients toward alternative drugs that their insurance prefers, even if those alternatives are less effective for their condition.
- **Unexpected financial burden:** Patients who rely on copay assistance might be caught off guard when they suddenly face high out-of-pocket costs later in the year.

Why are CMPs controversial?

Copay maximizer programs are controversial because, while they lower patients' monthly costs, they can lead to higher long-term expenses and limit access to necessary medications. In addition to other major drawbacks of CMPs mentioned earlier, CMPs seem to also benefit insurers and PBMs more than patients by:



- **Maximizing drug company contributions:** These programs ensure insurers and PBMs get the full amount of copay assistance, reducing their costs while shifting more financial responsibility to patients.
- **Not reducing the price of drugs:** While insurers claim these programs help control costs, they do nothing to reduce the actual price of medications, leaving patients stuck with high expenses in the long run.

What are lawmakers saying?

Increase financial burden on patient

Many lawmakers believe that by preventing manufacturer assistance from counting toward deductibles and out-of-pocket maximums, copay maximizers leave patients with higher costs in the long run.

Lack transparency

Some legislators argue that insurers and PBMs are not upfront about how these programs work, leading to unexpected financial hardships for patients.

Interfere with drug access

Lawmakers worry that these programs push patients toward insurer-preferred drugs instead of what their doctors originally prescribed.

Final thoughts

While insurers and PBMs defend copay maximizers as a way to control costs, lawmakers on both sides of the aisle are increasingly questioning their fairness and impact on patients.

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Accumulator Adjustment Programs

What are accumulator adjustment programs?

Accumulator Adjustment Programs (AAPs) are cost-management strategies used by some health insurers and pharmacy benefit managers (PBMs). These programs **change how payments made by third parties, like drug companies, count toward a patient's deductible and out-of-pocket maximum.**

How do they work?

Health insurance plans often have a **deductible**, which is the amount a patient must pay before insurance starts covering costs. Many drug manufacturers offer **copay assistance programs or coupons** to help patients afford expensive medications by covering part or all of their copay.

Traditionally

Both the patient's payments and third-party copay assistance counted toward the deductible and out-of-pocket maximum, helping patients meet these limits faster.

With AAPs

The insurer **does not count** third-party payments toward the deductible or out-of-pocket maximum. As a result, once the copay assistance runs out, the patient must still pay their full deductible and maximum costs before insurance provides full coverage.

Key Takeaway: AAPs prevent copay assistance from reducing a patient's total financial responsibility, leading to higher out-of-pocket costs over time.

Why are these programs used?

Insurers and employers argue that AAPs help control rising drug costs by:

- **Ensuring patients contribute to health care costs** rather than relying entirely on manufacturer discounts.
- **Encouraging the use of lower-cost alternatives**, such as generics, when available.

Not all medications have generic equivalents. In those cases, **AAPs may leave patients without a lower-cost option, forcing them to pay significantly more for necessary treatments**.

Impact on patients

AAPs can create financial hardships for patients, especially those with chronic conditions requiring costly medications. Key concerns include:

Increased out-of-pocket expenses
Patients may face unexpected costs when they realize copay assistance didn't count toward their deductible.

Delayed deductible fulfillment
Patients must pay more before insurance coverage kicks in, even if they received copay help.

Risk of treatment disruption
Some patients may be forced to skip or stop taking their medication due to cost.

Criticism and legal challenges

AAPs have been widely criticized by:

Patient advocacy groups and health care providers who argue these programs make lifesaving medications unaffordable for those who need them most.

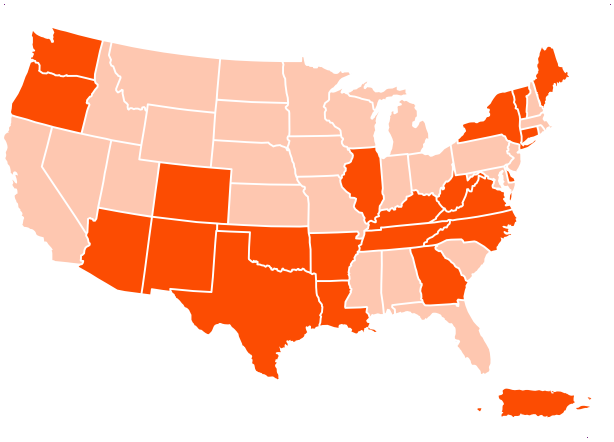
Policymakers who believe AAPs undermine the purpose of copay assistance and place undue financial stress on patients.

Some patients **abandon their prescriptions entirely** because of the unexpected costs imposed by these programs.

State action

According to the National Council of State Legislators (NCSL), as of 2024:

- **21 states, Washington D.C., and Puerto Rico** require insurers and PBMs to apply third-party payments toward a patient's cost-sharing requirements.
- **More states are considering similar legislation** in 2025.



Federal action

Federal policy on AAPs has been inconsistent:

- **2020 & 2021 Centers for Medicare and Medicaid Services (CMS) Rules**: CMS allowed insurers to use AAPs, deferring regulation to state laws.
- **2023 Federal Court Ruling**: A court struck down the 2021 rule, blocking insurers from applying AAPs to medications **without a generic alternative**.

Conclusion

Accumulator Adjustment Programs are a **controversial tool** used by insurers to manage prescription drug costs. While they may help control overall health care spending, they also place a **greater financial burden** on patients who rely on copay assistance. As laws and regulations continue to evolve, the debate over AAPs will likely persist—balancing cost-saving measures with ensuring patient access to affordable medications.

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Loss of Coverage – What Are Your Options?

COBRA is a special rule that helps people keep their health insurance if they lose their job or their work hours are reduced. Normally, when you leave a job, your health insurance from that job ends. But with COBRA, you can choose to keep the same insurance plan for a specific period of time, usually up to 18 months.

How much does COBRA cost?

COBRA can be expensive. While employed, your employer may have paid a portion of the cost for your health insurance. With COBRA, you will pay both your part and the employer's part, plus a small fee. This means the monthly cost can be much higher than what you paid before.

What services are covered?

Under COBRA, you remain covered under the same health plan you had while you were working. This means you continue to have the same benefits and can keep going to the same doctors, get the same medicines, and receive the same services, like check-ups, hospitalization, or treatments.

How do you sign up for COBRA?

- **Notice from employer:** When you leave a job or have reduced hours, your employer will give you a letter or notice explaining COBRA and how to sign up.
- **Electing COBRA:** You usually have 60 days to decide if you want to sign up for COBRA. If you decide to sign up, you will start paying the higher cost to keep your health insurance.
- **Payments:** Once you start COBRA, you will need to keep paying every month to stay covered.

Other health insurance options

If COBRA is too expensive, you have other ways to get health insurance:

- **Marketplace insurance:** You can go to the Health Insurance Marketplace (like Healthcare.gov) to find a new health plan. Sometimes, you might qualify for discounts, which can make it more affordable.
- **Medicaid:** If your income is low, you might qualify for Medicaid, a program that provides free or low-cost health insurance.
- **Spouse plan:** If you have a spouse (husband, wife, or domestic partner) with a job that offers health insurance, you may be able to join their plan.

Other health insurance options (continued)

- **Short-term insurance:** This is a type of insurance that lasts for a limited time, such as a few months, until you find a long-term plan. However, these plans typically have limited coverage and may not cover everything you need so it is ESPECIALLY important that you read the plan documents carefully before choosing this option.

Choosing health insurance can be tricky, so it is helpful to compare costs and options before deciding.

Resources

https://www.dol.gov/general/topic/health-plans/cobra

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Understanding Surprise Billing and the Law to Stop It

What is surprise billing?

Imagine this: You go to the hospital for an emergency or a procedure, and later you get a bill in the mail that you were not expecting. This is called a **surprise bill**. Surprise billing happens when you get care from a doctor or a hospital that is not in your health insurance's "network."

Your health insurance network is a group of doctors, hospitals, and clinics that have agreed to lower costs for patients in that plan. Sometimes, you might not know if a doctor or hospital is not in your network—especially if it is an emergency or you are not the one picking the doctor

Here are some common ways surprise bills can happen:

- **Emergency situations:** If you're in an accident and go to the nearest hospital, that hospital might not be in your network. You might also see doctors who aren't in your network while you're there.
- **Planned surgeries:** Even if you choose an in-network hospital and surgeon, there might be other providers (like anesthesiologists or radiologists) who are not in your network.

When this happens, your insurance might not cover as much of the cost, and you end up with a surprise bill.

The law to stop surprise billing

To protect people from these unexpected costs, the government passed a law called the "No Surprises Act." This law started in January 2022 and helps prevent surprise billing in many situations. Here is how it works:

- **Emergency care protection:** If you have an emergency and go to a hospital that is not in your network, you cannot be charged extra just because the hospital isn't in your network. You will pay the same as if you went to a hospital that is in your network.
- **Non-emergency situations:** If you go to an in-network hospital or facility for planned care, you should not get a surprise bill from any of the providers who treat you there—even if they are out-of-network.
- **No balance billing:** Balance billing is when a provider charges you the difference between what they want to be paid and what your insurance is willing to pay. The new law says providers cannot do this in most situations where surprise billing might happen.
- **Advance notice:** If you are going to get care from an out-of-network provider, the provider must tell you beforehand and give you an estimate of what it might cost. You can choose to agree to it or find another provider if you do not want to pay extra.

Why this law matters

Surprise billing has caused big problems for people who get huge, unexpected medical bills. Many families have faced thousands of dollars in bills for which they did not plan. The "No Surprises Act" makes healthcare costs fairer by giving people more protection in emergencies and more information before getting non-emergency care.

Key points to remember

- **Surprise billing"** is when you get a bill from a provider outside your insurance network without knowing it.
- **The No Surprises Act** stops most surprise bills for emergency care and some non-emergency situations.

Providers must give you **"advance notice"** if they are out of network and tell you the estimated costs.

Now, thanks to this law, you are better protected from surprise bills! This can help families avoid unexpected costs and plan better for healthcare expenses. For more information visit No Surprises Act.

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What is a Summary of Benefits?

A Summary of Benefits is a document provided by health insurance companies that outlines the key features and details of a health plan's coverage. It is designed to give you a clear understanding of what the plan covers, does not cover, and the associated costs.

Key elements typically included in a Summary of Benefits are:

- **Covered services:** A list of medical services and treatments that are included under the plan. This typically includes doctor visits, hospital stays, prescription drugs, and preventive care.
- **Costs:** Information on costs such as premiums, deductibles, copayments, and coinsurance that you are responsible for paying.
- **Out-of-pocket maximum:** The maximum amount you would have to pay out of your own pocket during a coverage period (usually a year). After you reach your out-of-pocket maximum, the plan pays 100% of the covered services.
- **Network information:** Details about the network of health care providers that the plan covers. This includes whether you can see out-of-network providers and at what cost.
- **Limitations and exclusions:** Any specific services or treatments that are not covered under the plan.
- **Prior authorization requirements:** Information about which services require approval from the insurance company before they are covered.

The Summary of Benefits and coverage will include a standardized health plan comparison tool for consumers called "coverage examples." The coverage examples illustrate how a health insurance policy (plan) would cover care for common benefits scenarios. Using clear standards and guidelines provided by the Center for Consumer Information and Insurance Oversight (CCIIO), plans and issuers will simulate claims processing for each scenario. This allows consumers to see an illustration of the coverage they receive under a plan.

CCIIO sample summary of benefits and coverage

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Health Care and Insurance Related Acronyms

ACA	Affordable Care Act
APTC	Advanced Premium Tax Credit
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CSR	Cost-Sharing Reduction
DUR	Drug Utilization Review
DME	Durable Medical Equipment
ED	Emergency Department
EHB	Essential Health Benefits
EMR	Electronic Medical Record
EOB	Explanation of Benefits
EPO	Exclusive Provider Organization
ERISA	Employee Retirement Income Security Act
ESI	Employer-sponsored Insurance
FDA	Food and Drug Administration
FFS	Fee-for-service
FPL	Federal Poverty Level
FSA	Flexible Spending Account
HSA	Health Savings Account
HDHP	High Deductible Health Plan
LTC	Long Term Care
MCO	Managed Care Organization
MLR	Medical Loss Ratio
MOOP	Maximum Out-of-Pocket
OEP	Open Enrollment Period
OON	Out-of-Network
OOP	Out-of-Pocket
PA	Prior Authorization
PBM	Pharmacy Benefit Manager
PCP	Primary Care Provider
PDL	Preferred Drug List
POS	Point-of-Service Plan
PPO	Preferred Provider Organization
QHP	Qualified Health Plan
SBC	Summary of Benefits and Coverage
SEP	Special Enrollment Period
SNF	Skilled Nursing Facility
SPP	Specialty Pharmacy Provider
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
TPA	Third Party Administrator

Health Care and Insurance Related Terms

A

Accountable Care Organization (ACO)

A group of health care providers that give coordinated care for chronic disease management with the goal of improving the quality of patient care. The "organization's" payment is tied to achieving health care quality goals and outcomes that result in cost savings. ACOs can include various types of doctors – primary care, specialists, etc. – as well as other medical providers (nurses, physician's assistants, etc.) and institutions (hospitals, multi-physician practices).

Advanced Premium Tax Credit (APTC)

Also referred to as a premium tax credit, this tax credit provided for in the Affordable Care Act helps make coverage purchased in the Marketplace more affordable for consumers. Advance payments of the tax credit can be used right away to lower monthly premium costs. If the amount of advance credit payments a consumer gets for the year is less than the tax credit, the consumer will get the difference as a refundable credit when they file their federal income tax return. If the consumer's advance payments for the year are more than the amount of their credit, they must repay the excess advance payments with their tax return.

Affordable Care Act (ACA)

Also known as the Patient Protection and Affordable Care Act (PPACA), health care reform (HCR) and Obamacare, it is the comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: PPACA was signed into law on March 23, 2010. It was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The Affordable Care Act refers to the final, amended version of the law.

Affordable Coverage (as it relates to the APTC)

Employer coverage is considered affordable - as it relates to the Advanced Premium Tax Credit (APTC) - if the employee's share of the annual premium for self-only coverage is no greater than 8.39% of annual household income.

Allowed Amount

Discounted fees that insurers will recognize and pay for covered services. Insurers negotiate these discounts with providers in their health plan network. Network providers agree to accept the allowed charge as payment in full. Each insurer has its own schedule of allowed charges. If you go out-of-network to obtain care, you may be asked to pay the difference between the allowed amount and the provider's charge, known as balance billing.

Annual Limit

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

Appeal

A request for a health insurer or plan to review a decision to deny coverage for a service, either the payment for services received or prior approval for a service, your doctor has recommended for you.

B

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. Balance billing may occur when an individual goes out of network for care, whether intentionally or unintentionally. The No Surprises Act bans balance billing, particularly when individuals obtain out-of- network care unintentionally, known as "surprise billing."

Benefits

The health care items or services covered under a health insurance plan. Covered benefit and excluded services are defined in the health insurance plan's coverage documents.

Biologic

A biologic (also known as a biological product) is a type of complex medication such as a vaccine, blood or blood product, or other treatment that mimics proteins naturally present in the body. Rather than being created chemically like drugs, biologics are based of recombinant, cell or tissue-based proteins.

Biosimilar Biological Products

A biosimilar is the "follow-on" or subsequent version of a biologic. Biosimilars and biologic products have the same relationship that generic drugs have with brand name drugs, with an important distinction that due to their complexity, biosimilars are not identical to the original biologic product.

Bronze Health Plan

A plan in the health insurance Marketplace where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 60%.

C

Capitation

A method of paying for health care services where providers receive a set payment for each person instead of receiving payment based on the number of services provided.

Care Coordination

The process of organizing your treatment across several health care providers. Medical homes and Accountable Care Organizations (see definition) are two common ways to coordinate care.

Center for Consumer Information and Insurance Oversight (CCIIO)

Located within the Centers for Medicare & Medicaid Services (part of the Department of Health & Human Services), the Center is the federal agency tasked with implementing many provisions of the Affordable Care Act related to private health insurance.

Centers for Disease Control and Prevention (CDC)

The federal agency responsible for protecting health and promoting quality of life through the prevention and control of disease, injury, and disability.

Centers for Medicare and Medicaid Services (CMS)

The federal agency that administers the Medicare, Medicaid, and Children's Health Insurance Programs, and implements many provisions of the ACA related to the health insurance Marketplaces.

Children's Health Insurance Program (CHIP)

Insurance program jointly funded by state and federal government that provides health insurance to low-income children. In some states, it covers pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage.

Children with Special Health Care Needs (CSHCN)

Maternal and Child Health Bureau (MCHB) defines CSHCN as those children that have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Claim

A request for payment that you or your health care provider submits to your health insurer after you receive covered items or services.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A federal law that may allow you to temporarily keep health coverage if your employment ends or you are no longer eligible for coverage, you lose coverage as a dependent of the covered employee, or if there is another qualifying event. COBRA requires you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Coinsurance

A form of cost sharing that requires an insured person to pay a fixed percentage (rather than a set dollar amount) of expenses after the deductible amount, if any, was paid until the patient reaches their maximum out of pocket cost.

Note: coinsurance percentage amounts may differ depending on if the service or procedure was received by an in network or out of network provider or facility. Review your plan's Summary of Benefits document closely.

Consumer Assistance Program (CAP)

State programs are available to assist consumers with problems or questions concerning health care coverage. Consumers with questions can usually access the programs through phone or e-mail. See https://www.cms.gov/cciio/resources/consumer-assistance-grants.

Coordination of Benefits

A way to figure out who pays first when two or more health insurance plans are responsible for paying the same medical claim.

Copayment

A flat dollar amount you must pay for a covered program. Example: you may have to pay a $15 copayment for each covered visit to a primary care doctor.

Note: copayment amounts differ depending on if the service or procedure was received by an in network or out of network provider or facility. Review your plan's summary of benefits document to determine the difference.

Copay Maximization Allowance Programs (also known as Copay Allowance Maximization Programs):

Generally, target a narrow list of specialty medications allowing plans to take advantage of the full annual value of the manufacturer copay coupons available on those drugs by increasing the beneficiary's monthly specialty copay amount, up to the monthly value of the copay coupon (annual face value of manufacturer copay coupon, divided by 12). Unlike the copay accumulator adjustment programs, the amount collected doesn't count towards the out of pocket. Given that this type of program changes the copays on some drugs (drug specific copays), health plans are required to update their summary plan description, making it more challenging for plans to implement. The uptake on these programs has been far more limited than that of the copay accumulator adjustment programs.

Cost Sharing

The share of costs covered by your insurance that you pay out-of-pocket. This share is commonly referred to as out-of-pocket (OOP) costs. The ACA sets an annual limit on out-of-pocket costs, which includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, or the cost of non-covered services.

Note: separate cost sharing limits apply in Medicaid and CHIP, which include premiums.

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 reduction only if you get health insurance through the Marketplace, your income is below a certain level, and you choose a Silver Health Plan (See "Metal Tiers" and "Silver Health Plan"). If you're a member of a federally recognized tribe, you may qualify for additional cost- sharing benefits.

D

Deductible

The amount you must pay for covered care before your health insurance begins to pay. Insurers apply and structure deductibles differently. Example: under one plan, a comprehensive deductible might apply to all services while another plan might have separate deductibles for benefits such as prescription drug coverage. Deductibles for family plans may be embedded or non-embedded. Under an embedded deductible, each family member must meet their own deductible until the overall family deductible amount has been met. Under a non-embedded deductible, the overall family deductible must be met before the plan begins to pay.

Dependent

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

Dependent Coverage

Insurance coverage for family members of the policyholder, such as spouse, children or partners. Under the ACA, all plans offering dependent coverage must cover dependents up to age 26, regardless of whether they are dependent, live at home, or are a student.

Disability

A limit in action, restriction or impairment that can be physical and/or mental. Different state, federal or private programs may have different disability standards. A legal definition of disability can be found at: www.ada.gov/pubs/ada.htm.

Donut Hole, Medicare Prescription Drug

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. For more information: Medicare Part D Donut Hole.

Drug Utilization Review (DUR)

It is an ongoing review of prescribing, dispensing and use of medication. It is often used as a utilization management tool to control and promote more efficient use of scarce health care resources.

Dual Eligibles

A term used to describe an individual who is eligible for Medicare and for some level of Medicaid. Most duals qualify for full Medicaid benefits including nursing home services, and Medicaid pays their Medicare premiums and cost sharing. For other duals Medicaid provides the "Medicare Savings Programs" through which enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements.

E

Early Periodic Screening, Diagnostic & Treatment Services

The comprehensive set of benefits covered for children in Medicaid.

Electronic Medical Record (EMR)

A digital version of a paper chart that contains all of the patient's medical history from one practice.

Eligible Immigration Status

An immigration status that's considered eligible for getting health coverage through the Marketplaces. The rules concerning eligible immigration status differ for Medicaid and Marketplace coverage.

Emergency Department (ED)

Medical treatment facility that provides emergency room services.

Emergency Room Services

Evaluation and treatment of an illness, injury, or condition that needs immediate medical attention in an emergency room.

Employer Mandate

The ACA requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to their full-time employees and their dependents (but not spouses) that meet certain minimum standards.

Employer-Sponsored Insurance (ESI)

This is health insurance provided by an employer, who typically covers a portion of the costs. Sometimes it is called group health insurance. Plan options may include HMOs, PPOs, and EPOs, among others.

Employee Retirement Income Security Act of 1974 (ERISA)

A federal law that establishes standards for employer-sponsored health insurance, particularly for self-insured employer-sponsored plans. (See Self-Insured Plan). Some employer plans are subject to state health insurance laws, in particular, small employer plans. Most large employer plans (sometimes referred to as "ERISA plans") and all self-insured plans are subject only to ERISA and not state health insurance laws. In the context of the ACA, ERISA plans are also exempt from some of the private health insurance reforms.

Essential Health Benefits (EHB)

A set of health care service categories that must be covered by certain plans. The ACA defines essential health benefits to "include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care."

EHB services are defined differently in each state, based on what is covered by their benchmark plan. Private health insurance policies sold to individuals and small employers must cover these benefits, regardless of whether the policy is offered inside or outside the Marketplaces. Only grandfathered individual health insurance policies may still impose an annual limit.

Exclusions

Items or services that aren't covered under a contract for insurance and which an insurance company will not pay for.

Exclusive Provider Organization (EPO) Plan

A managed care plan in which services are covered only if you go to doctors, specialists or hospitals in the plan's network (except in an emergency). EPOs are similar to HMOs except that individuals may not need a referral from a primary care physician to see a specialist.

Explanation of Benefits (EOB)

A form sent by an insurance company to an insured that includes such items as a summary of the claims processed for an insured since their last claim, a summary of what the insurer paid for the claim and what the insured's responsibility may be, and a summary of the person's year-to-date costs in the plan.

External Review

A review of a plan's decision to deny coverage for or payment of a service by an independent third-party not related to the plan. If the plan denies an appeal, an external review can be requested. In urgent situations, an external review may be requested even if the internal appeals process is not yet completed.

External review is available when the plan denies treatment based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; when the plan determines that the care is experimental and/or investigational; or for rescissions of coverage. An external review either upholds the plan's decision or overturns all or some of the plan's decision. All parties must accept this decision.

F

Federal Marketplace

A Marketplace that is run by the federal government. All Marketplaces must meet federal rules. States that operate their own Marketplace may have different rules but must meet federal minimum standards.

Federal Poverty Level (FPL)

A measure of income level issued annually by the Department of Health and Human Services. FPL is used to determine eligibility for certain programs and benefits. FPL varies based on family size. For more information on FPL please visit: https://aspe.hhs.gov/topics/poverty-economic-mobility. Many public health insurance programs set eligibility based on a percentage of the FPL.

Fee for Service (FFS)

A reimbursement plan in which doctors and other health care providers are paid for each service performed, such as for tests and office visits.

Flexible Spending Account (FSA)

Accounts offered and administered by employers that allow employees to set aside pre-tax dollars out of their paycheck to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to an FSA. Typically, benefits or cash must be used within the given benefit year, or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Food and Drug Administration (FDA)

Is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA also provides accurate, science-based health information to the public.

Fully Insured Employer based Plan

A plan in which the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

G

Gold Health Plan

A plan in the health insurance Marketplaces where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 80%.

Grandfathered Health Plan

As defined in the ACA, a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempt from many changes required under the ACA.

Plans or policies may lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan documents if it is a grandfathered plan. It must also advise consumers how to contact the U.S. Department of Labor or HHS with questions.

Grievance

A complaint an insured communicates to his or her health insurer or plan.

Guaranteed Issue

A requirement that health plans must permit you to enroll regardless of health status, age, gender or other factors that might predict the use of health services. However, you can generally only enroll in coverage during an annual open enrollment period.

Guaranteed Renewal

A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums.

H

Habilitative/Habilitation Services

Health care services that help you keep, learn, or improve skills and functionality for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitative services are one of the 10 essential health benefits (EHBs).

Health Insurance Marketplace

Also known as a health insurance Exchange, these are new transparent and competitive health insurance Marketplaces where individuals and small businesses can buy qualified health plans that meet certain benefit and cost standards. Every state has a Marketplace.

Health Insurance Portability and Accountability Act (HIPAA)

HIPPA is a 1996 law that eliminated discrimination by health insurers for those with pre-existing medical conditions. It also sets important privacy and security standards for health care entities so that consumers' health information is protected.

Health Maintenance Organization (HMO)

An insurance plan that usually limits coverage to care by doctors who work for or contract with the HMO and will require you to get a referral from your primary care physician to see a specialist. Generally, it won't cover out-of- network care except in an emergency and may require you to live or work in its service area to be eligible for coverage.

Health Resources and Services Administration (HRSA)

An agency of the U.S. Department of Health and Human Services that works to improve access to health care services for people.

Health Savings Account (HSA)

A tax-exempt medical savings account that can be used to pay for current or future qualified medical expenses. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Employers may make HSAs available to their employees or individuals can obtain HSAs from most financial institutions. In- order to open an HSA, an individual must have health coverage under an HSA-qualified high deductible health plan (HDHP). Unlike a Flexible Spending Account (FSA), funds roll over year to year if you don't spend them.

High-Deductible Health Plan (HDHP)

A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more of the health care costs yourself before the plan starts to pay its share (your deductible). An HDHP that meets federal standards for a minimum deductible can be combined with a health savings account (HAS) to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

Home and Community-based Services

Services and support provided by most state Medicaid programs in your home or community that give help with such daily tasks as bathing or dressing. Covered when provided by care workers or, if your state permits it, by your family.

Home Health Care

Health care services and supplies in your home that a doctor prescribes.

I

Individual Health Insurance Policy

Policies for people who aren't connected to job-based coverage. Individual health insurance policies are regulated under state and federal law. Note that the phrase "individual policies" when used in this way – policies that are unconnected to employment – can be used for policies that cover a single person or multiple people (families, mother and dependent child, husband and wife, etc.).

L

Lifetime Limit

A cap on the total lifetime benefits your insurance policy will cover (also known as a lifetime cap). Before passage of the ACA, many insurers set a lifetime dollar limit on benefits (like $1 million) and would not pay for covered services once the limit was hit. As of September 2010, non-grandfathered health plans can no longer set lifetime dollar limits on the Essential Health Benefits (EHBs). Plans can continue to limit specific benefits by number (for example, covering only a certain number of visits).

Long-Term Care (LTC)

Medical and non-medical services provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term support and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term support and services at any age. Medicare and most health insurance plans don't pay for long-term care.

M

Managed Care Organization (MCO)

A group or organization that provides managed care plans.

Managed Care Plan

A plan that generally provides comprehensive health services to its members and offers financial incentives for patients to use the providers who belong to the plan. Examples include health maintenance organizations (HMO), preferred provider organizations (PPO), exclusive provider organizations (EPO) and point of service plans (POS).

Managed Care Provisions

Features within health plans that provide insurers with a way to manage the cost, use and quality of health care services received by group members. Examples of managed care provisions include:

- Preadmission certification - Authorization for hospital admission given by a health care provider to a group member prior to hospitalization. Failure to obtain a preadmission certification in non- emergencies reduces or eliminates the health care provider's obligation to pay for services rendered.
- Utilization review - The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during or after the services are rendered.
- Preadmission testing - Requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to nonemergency hospital admission. The testing is designed to reduce the length of a hospital stay.

- Nonemergency weekend admission restriction - A requirement that imposes limits on reimbursement to patientsfor nonemergency weekend hospital admissions.
- Second surgical opinion - A cost- management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a nonemergency or elective surgery be performed. Programs may be voluntary or mandatory in that reimbursement is reduced or denied if the participant does not obtain the second opinion. Plans usually require that such opinions be obtained from board- certified specialists with no personal or financial interest in the outcome.

Maximum Out-of-Pocket (MOOP)

A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost.

Medicaid

A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding and sets guidelines. States also have choices in how they design their program, so Medicaid programs and eligibility vary from state to state and may have a different name in your state. Under the ACA, states have the option to expand Medicaid coverage to all individuals with income under 138% of the FPL.

Medically Necessary

Services or supplies that are needed for the diagnosis or treatment of your health condition and meet accepted standards of medical practice.

Medicare

A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (ESRD)/ Medicare is composed of four parts:

Medicare Part A

Hospital insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice and home care. Most beneficiaries are enrolled in Part A automatically.

Medicare Part B

Medical coverage that helps to cover medically necessary services like doctors' services, outpatient care, home health services and other medical services. Part B also covers some preventive services, and physician-administered drugs like clotting factor. Most beneficiaries are enrolled in Part B automatically.

Medicare Part C/Medicare Advantage (MA)

A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. There are many types of Medicare Advantage Plans (MAP) including HMOs, PPOS, Private Fee-for-Service Plans, Special Needs Plans and Medicare Medical Savings Account Plans. If you're enrolled in an MA plan, Medicare services are covered through the plan and aren't paid for under Parts A and B Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Part D

An optional program that provides prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Minimum Essential Coverage (MEC)

The type of coverage an individual must have to meet the individual responsibility requirement under the ACA. This includes policies sold through a health insurance Marketplace, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. The summary of benefits and coverage (SBC) for your plan must tell you if the plan is MEC. Note that some plans sold outside the Marketplace to individuals do not meet these standards and will not count toward the requirement to have coverage. Check with the insurance company for the plan to confirm whether it is "minimum essential coverage."

Modified Adjusted Gross Income (MAGI)

The figure used to determine eligibility for lower costs in the Marketplace/Exchange and for Medicaid and CHIP. Generally, modified adjusted gross income is your adjusted gross income plus any tax-exempt Social Security, interest, or foreign income you have.

N

Navigator

An individual or organization that's trained to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplaces established pursuant to the ACA. Navigators assist consumers with completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased, and their services are free to consumers.

Nondiscrimination

A requirement that job-based insurance not discriminate based on health status by denying or restricting health coverage or charging more. Job-based plans can restrict coverage based on other factors such as part-time employment that aren't related to health status.

O

Open Enrollment Period (OEP)

The time-period set up to allow you to choose from available plans, usually once a year.

Out-of-Pocket (OOP) Limit

The maximum amount you will be required to pay for covered services in a year, before the plan covers 100% of all costs. Generally, this includes the deductible, coinsurance, and copayments (varies from plan to plan), but not premiums. Plans can set different out-of-pocket limits for different services, and some plans do not have out-of-pocket limits.

P

Pay for Performance

A health care payment system where providers receive incentives for meeting or exceeding quality, and sometimes cost, benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

Pharmacy Benefit Manager (PBM)

Health plans and sponsors contract with Pharmacy Benefit Managers to handle the claims processing and administrative functions involved with prescription drug programs. In addition to processing and paying claims, PBMs develop and maintain a program drug formulary, contract with participating pharmacies and negotiate discounts and rebates with drug manufacturers.

Plan Year

A 12-month period of benefits coverage under a health plan. This 12-month period might be different than the calendar year, depending on when your health plan renews. Sometimes referred to as Policy year.

Platinum Health Plan

A plan in the health insurance Marketplaces where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 90%.

Point-of-Service Plan (POS) Plan

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 may also require you to get a referral from your primary care doctor in order to see a specialist.

Pre-Existing Condition

With certain limited exceptions, a pre-existing condition is any condition (physical, mental or a disability) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period before you enrolled in a health insurance plan. Before passage of the ACA, insurers could either not offer health insurance to you if you had a pre-existing condition or could refuse to cover any services related to a pre-existing condition (known as a pre-existing condition exclusion). Under the ACA non-grandfathered health insurance plans can't refuse to cover you or charge you more just because you have a pre-existing health condition.

Preferred Drug List (PDL)

A PDL is a list of medications that are covered without the need to obtain prior authorization. Drugs are designated as either preferred or non- preferred.

Preferred Provider Organization (PPO)

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

Premium

A monthly or annual payment you make to your insurer to get and keep insurance coverage. Premiums can be paid by employers, unions, employees or individuals or shared among different payers.

Prescription Drug Coverage

Health insurance or plan that helps pay for prescription drugs and medications.

Preventive Services

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

Primary Care

Health services that cover a range of prevention, wellness and treatment options for common illnesses. Primary care providers (PCP) include doctors, nurses, nurse practitioners and physician assistants. They advise and treat you on a range of health-related issues. They may also coordinate your care with specialists.

Primary Care Provider (PCP)

Includes doctors, nurses, nurse practitioners and physician assistants; they provide health services for a wide range of common illnesses, wellness and prevention.

Primary Care Case Management

A model of Medicaid managed care outlined in Medicaid law. State Medicaid agencies contract with primary care providers to provide, locate, coordinate, and monitor primary care services for Medicaid beneficiaries who select them or are assigned to them by the state. The primary care provider – usually a physician or a physician practice, but sometimes a nurse practitioner, physician assistant, or other provider – serves as a beneficiary's "medical home" for primary and preventive care. Under their contracts with primary care providers, states pay them a small monthly case management fee in addition to regular FFS payments.

Prior Authorization (PA)

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

Provider Network

A list of *doctors*, other health care *providers*, and hospitals that a plan contracts with to provide medical care to its members.

Out-of-network Provider

A duly licensed or certified institution or health professional not under contract with your insurance provider.

In-Network Provider

A duly licensed or certified institution or health professional under contract with your insurance provider.

Q

Qualified Health Plan (QHP)

An insurance plan that is certified by a health insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of- pocket maximum amounts) and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Qualifying Event

Any event or occurrence such as death, termination of employment, divorce or a terminal illness that changes an employee's eligibility status and permits an acceleration or continuation of benefits or coverage under a group health plan. The term is most frequently used in reference to COBRA eligibility.

R

Rate Review

A process that allows state insurance departments to review rate increases before insurance companies can apply them to you.

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.

Rider (Exclusionary Rider)

An amendment to an insurance policy. Some riders add coverage while other riders exclude coverage (known as exclusionary rider). Example: You buy a maternity rider to add coverage for pregnancy to your policy. An exclusionary rider is an amendment permitted in individual policies that permanently excludes coverage for a health condition, body part or body system (such as a certain disease state or disability). Under the ACA, no exclusionary riders will be permitted in non-grandfathered health insurance plan.

Risk Adjustment

A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

S

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. Self-insured plans do not follow state insurance rules. They are regulated under the federal rule known as ERISA and overseen by the U.S. Department of Labor.

Silver Health Plan

A plan in the health insurance Marketplaces where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 70%.

Skilled Nursing Facility (SNF) Care

Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Example: Physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Short-Term, Limited Duration Health Plans

These plans are low-cost, limited coverage insurance plans that are meant to help individuals who have a temporary gap in health insurance coverage. Insurers could offer a short-term plan for up to three (3) years. These plans typically do not cover pre-existing conditions, prescription drugs, or maternity care.

Small Business Health Options Program (SHOP)

The Marketplace is available to small businesses under the ACA. Small businesses buying plans in the SHOP select the plan and decide how much they pay toward employee premiums. Participating small businesses may qualify for a small business health tax credit worth up to 50% of their premium costs.

Social Security Disability Income (SSDI)

Income payable by the federal government to individuals who are determined to be totally disabled.

Supplemental Security Income (SSI)

Social Security administers this program. SSI pays monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older. Blind or disabled children may also receive SSI.

Special Enrollment Period (SEP)

A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage. Job-based plans must generally provide a special enrollment period of 30 days following certain life events that involve a change in family status (such as marriage or birth of a child) or loss of other job-based health coverage. Plans sold to individuals, including Marketplace plans, must provide 60 days to enroll.

Specialty Pharmacy Provider (SPP)

A pharmacy designated to provide specialized medication for complex, genetic, rare, and chronic health conditions. Specialty pharmacy providers may provide home health or nursing services.

State Based Marketplace

One type of Marketplace option. States opting for an SBM/SBE manage their own Marketplace in accordance with applicable federal laws.

State Continuation Coverage

A state-based requirement similar to COBRA that applies to group health insurance policies for employers with fewer than 20 employees. In some states, state continuation coverage rules also apply to larger group insurance policies and add to COBRA protections. Example: in some states, if you're leaving a job-based plan, you must be allowed to continue your coverage until you reach the age of Medicare eligibility. One type of Marketplace option for states under the ACA. States opting for an SPM/ SPE will have a Marketplace that is run by the federal and state government jointly.

Summary of Benefits and Coverage (SBC)

The ACA requires plans to offer this easy-to-read summary that lets you make apples-to- apples comparisons of costs and coverage between health plans. 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 monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or 65 or older. SSI benefits are different than Social Security retirement or disability benefits.

T

Third Party Administrator (TPA)

An individual or firm hired by an employer to handle claims processing, pay providers and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer. The TPA may often be a company you associate with health insurance, such as Aetna or Blue Cross, but in this role, it is not the actual insurer but simply managing the plan on behalf of the employer.

TRICARE

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

U

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Usual, Customary and Reasonable (UCR) Charges

A health care provider's usual fee for a service that does not exceed the customary fee in that geographic area and is reasonable based on the circumstances. Instead of UCR charges, PPO plans often operate based on a negotiated (fixed) schedule of fees that recognize charges for covered services up to a negotiated fixed dollar amount. Conventional indemnity plans typically operate based on UCR charges.

V

Veteran's Health Benefits

Veterans may be eligible for a broad range of services, including health care benefits, through the Veteran's Administration.

W

Waiting Period (Employer -Based coverage)

The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan. Applies to all new employees and is not based on health status. Under the ACA, employer plans cannot impose a waiting period of more than 90 days.

Well-Baby/Well-Child Visits

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. Under the ACA's rules for preventive services, well child visits may be covered without cost- sharing.

Wellness Programs

A program intended to improve and promote health and fitness that's usually offered through the workplace, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships and other incentives to participate. Examples: programs to help you stop smoking, diabetes management programs, weight loss programs and preventive health screenings.

Sources:

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