Health Care Glossary of Terms

A

Affordable Care Act The health reform law passed in 2010 aimed at changing America's health care system to improve access and affordability for more Americans.

Annual Deductible The amount of eligible expenses you are required to pay annually before reimbursement by your health plan begins.

Annual Dollar Limit A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. Limits may be placed on particular services or on the dollar amount of covered services.

Annual Out-of-Pocket The maximum amount per year you are required to pay out of your own pocket for covered health care services.

B

Benefits The health care items or services covered by an insurance plan, sometimes called a "benefit package."

C

Catastrophic Plan A health plan that has a lower premium than other health plans, but has a high deductible. It usually doesn't provide coverage for a lot of services that other plans typically cover. It is designed to provide a kind of "safety net" coverage in case you have an accident or serious illness. The Health Insurance Marketplace offers a catastrophic health plan option for people under 30 and to some low-income people.

Claim An itemized bill for services that have been provided to a plan member, spouse or dependent.

Coinsurance Your share of the costs of a covered health care service—usually a percentage of an eligible expense. For example, you may pay 20% of an allowed service while your plan pays 80%.

Copayment A fixed dollar amount you are required to pay for a covered service at the time you receive care.

Cost-sharing Assistance Federal funds available for eligible people to help reduce health insurance out-of-pocket costs such as deductibles, coinsurance or copayments.

Covered Person The person in whose name a health care policy is issued (the member) and—under family coverage—the member's dependents.

Covered Service A service that is covered according to the terms of your health care policy.

D

Deductible A fixed amount of expenses you are required to pay before you are reimbursed for a covered service. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible.

Dependent A person (generally a spouse or child) other than the member who receives health care coverage under the member's policy.

Drug Formulary A list of prescribed drugs covered by a health plan. Not all drugs are covered under a plan.

E

Effective Date The date your health care coverage begins.

Emergency Medical Care Services provided for treatment of a sudden onset medical condition, usually in a hospital.

Essential Health Benefits Most insurance plans you can choose from include coverage for certain benefits considered "essential" for basic good health.

Exchange See Health Insurance Marketplace.

Exclusions Specific medical conditions or circumstances that are not covered under a health plan. As of 2014, certain exclusions go away for most insurance plans. These include age, gender or pre-existing health problems.

Explanation of Benefits (EOB) The form sent to you after a claim has been processed by your health care provider. The EOB explains the actions taken on the claim, including the amount paid, the benefit available and the amount you may owe the provider, and other information, such as how to appeal a claim decision.

F

Family Coverage Health care coverage for a member and his or her eligible dependents.

Federal Poverty Level (FPL) A level of income used by the U.S. Department of Health and Human Services to determine eligibility for certain government programs and benefits. FPL is one factor that will be used to determine the amount of tax credits you may qualify for to help with the cost of buying health insurance through the Health Insurance Marketplace.

G

Group Plan A group of people covered under the same health care policy through the same employer or association.

Guaranteed Coverage The Affordable Care Act says that most individuals can enroll in some form of insurance regardless of health status, age, gender or other factors.

H

Health Insurance Marketplace Where Texans can shop for, compare and buy health insurance. The Marketplace is accessed via a website or with a phone call. Insurance plans are offered at various coverage and price levels.

I

Individual Health Insurance Plan Health care coverage an individual buys, rather than a plan offered through a job or group.

In-network Covered services provided or ordered by your primary care physician (PCP) or another provider who is in the specific network of providers that your health plan has contracted with.

Individual Mandate The Affordable Care Act requires most Americans and legal residents to get and maintain health insurance coverage. If you're not covered, you may be required to pay a penalty on your annual income tax return.

Inpatient Services Services provided when you are admitted into a health care facility, such as a hospital.

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

L

Lifetime Limit A cap on the total lifetime benefits you may get from your insurance plan, or for certain conditions. There is no lifetime limit on essential health benefits, such as emergency care and hospital stays.

M

Marketplace See Health Insurance Marketplace.

Medicaid A joint federally and state-funded program that provides health care coverage for low-income children and families, and for certain older or disabled people. A provision of the Affordable Care Act significantly expands the program in the states that agree to the expansion.

Medicare A federal program established to provide health care coverage for eligible senior citizens and certain disabled people under age 65.

Member The person a contract holder (an employer or insurer) has agreed to provide coverage for, sometimes referred to as the insured or insured person/subscriber.

N

Network The doctors, hospitals and other health care providers that are contracted with to deliver health care services to members/subscribers in your health plan.

O

Open Enrollment Period The period when you make changes to your health plan coverage or choose a new health plan. They usually occur each fall. The individual open enrollment period for 2018 coverage begins **Nov. 1, 2017**, and goes through **Dec. 15, 2017**.

Out-of-Network Services provided by health care professionals or at facilities that are not in the network of contracted providers and facilities in your health plan.

Out-of-Pocket Maximum The maximum amount you have to pay for expenses under your health plan during a certain benefit period. This protects you in case of serious or expensive medical conditions.

Outpatient Services Treatment provided to you without an overnight stay in a hospital or other inpatient facility.

P

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

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

Primary Care Physician (PCP) The physician you choose to be your primary source for medical care and who coordinates all your medical care, including hospital admissions and referrals to specialists. HMO Plans require you to select a PCP to direct your care.

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

S

Subsidy See Cost-sharing Assistance.

T

Tax Credits To help you afford health insurance, you may qualify for tax credits to help with insurance costs when you enroll in coverage through the Health Insurance Marketplace.