UNIVERSITY OF MARYLAND EXTENSION
Solutions in your community

SMART CHOICE HEALTH INSURANCE

UNIVERSITY OF DELAWARE COOPERATIVE EXTENSION

Health Insurance Important Words to Know

Cost Terms

Term	Definition
Allowed Amount	Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate."
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.
Coinsurance	Your share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service.
Copayment	A fixed amount you pay for a covered health care service, usually when you get the service, and can vary based on the type of service.
Deductible	The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.
Fixed Health Care Expense	A medical or health care expense that stays the same each month or year. An example includes monthly premium payments.
Flexible or Periodic Health Care Expense	A medical or health care expense that changes based on the use of services.
Medical Expenses	Expenses that include costs of health care. Examples include insurance premiums, coinsurance or copayments to doctors, dentists or other providers, costs associated with prescriptions, hospitalization, medial aids/devises/glasses, and medical related travel. The IRS has specific definitions of these costs and depending on your total health care costs, some of these may be included as a tax deduction on your taxes. May also be called Health Care Expenses.
Medical Identity Theft	The theft of personal information in order to obtain medical care, pharmaceutical services or even insurance coverage. As a result, false entries may be placed into the victim's existing medical records and impact the health care or insurance coverage of the victim.
Out-of-Pocket Costs	Your expenses for medical care that are not reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance and copayments for covered services plus all costs for services that are not covered.

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Out-of-Pocket Maximum	The most you pay during a policy period (usually one year) before your health insurance plan starts to pay 100% for covered health benefits. This limit must include deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual that is a qualified expense. This limit does not have to count premiums, balance billing amounts for non-network providers and other out-of-network cost sharing, or spending for non-essential health benefits.
Premium	The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.
Qualified Medical Expense	The amount paid for the diagnosis, cure, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. There are many different types of medical expenses that would qualify. Qualified expenses are defined by IRS code. You can find out what these are by going to: http://www.irs. gov/pub/irs-prior/p502--2013.pdf

Types of Health Insurance Plans

Exclusive Provider Organization (EPO)	A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency)
Health Maintenance Organization (HMO)	A type of health insurance plan that limits coverage to care provided by doctors who work for or contract with the HMO. It generally will not 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.
Point of Service (POS) plans	A type of plan in which you pay less if you use health care providers that belong to the plan's network. Requires you to get a referral from your primary care doctor in order to see a specialist.
Preferred Provider Organization (PPO)	A type of health plan that contracts with medical providers to create a network of participating providers. You pay less if you use providers that belong to the plan's network.

Description of the Tiers

Bronze	The health insurance company will cover 60% of health service costs for an average person; your coinsurance on average will be 40% of costs.

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	Plans in this tier have the lowest premiums but the highest out-of-pocket costs.
Silver	The health insurance company will cover 70% of health service costs for an average person; your coinsurance on average will be 30% of costs. Plans in this tier have low premiums and high out-of-pocket cost.
Gold	The health insurance company will cover 80% of health service costs for an average person; your coinsurance on average will be 20% of costs. Plans in this tier have high premiums and low out-of-pocket costs.
Platinum	The health insurance company will cover 90% of health service costs for an average person; your coinsurance on average will be 10% of costs. Plans in this tier have the highest premiums and the lowest out-of-pocket costs.

Types of Medical Savings Accounts

Flexible Savings Account (FSA)	An account you contribute money using pre-tax dollars. You can then be reimbursed for qualified medical expenses. FSA accounts are available as part of your employer's benefits plan package; you cannot open one as an individual consumer. The amount you choose to save is automatically deducted from your paycheck and is placed in an account managed by a third party agency. These accounts have set time period and at the end of the year or grace period, you may lose any money left over in your FSA; plan carefully.
Health Savings Account (HSA) also known as Health Retirement Accounts (HRA)	A medical savings account available to you if you have a HSA-qualified, high-deductible health insurance plan (HDHP). This account allows you to save pre-tax dollars for qualified medical expenses. Contributions can be made by you and/or your employer, but you are the account owner. Key advantages to HSAs are you can build the account balance by earning interest on what you set aside and this can be used to pay for future health care costs and you do not pay taxes on the earned interest. There are limits on how much you can set aside each year and provisions about how you can use the money before retirement and after.

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Health Insurance Important Words to Know

Essential Health Benefits — A set of health care service categories that must be covered by certain plans as of 2014.

Term	Definition
Ambulatory patient services	Health services provided on an outpatient basis to those who visit a hospital or another health care facility and depart after treatment on the same day.
Chronic disease management	An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve your quality of life while reducing your health care costs by preventing or minimizing the effects of a disease.
Emergency services	Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
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.
Habilitative services	Health care services that help you keep, learn, or improve skills and functioning for daily living.
Hospitalization	Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.
Mental health and substance use disorder services	Treatment and services to improve mental health and to address substance use disorders, including behavioral health treatment, counseling and psychotherapy.
Oral care (Pediatric)	Benefits that help pay for the cost of visits to a dentist for basic or preventive services, like teeth cleaning, X-rays, and fillings.
Preventive services	Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.
Rehabilitative 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.
Vision services (Pediatric service)	Health benefit that at least partially covers vision care, like eye exams and glasses.

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Health Insurance Important Words to Know

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.
Wellness services	A program intended to improve and promote health and fitness that is 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.
Providers of Health Care Services	
Navigator	An unbiased individual or organization trained and able to help consumers and small businesses as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. Their services are free to consumers.
Network	The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services. A provider who is part of the plan is considered "in-network" where as a provider not part of the plan is considered "out-of-network".
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.
Specialists	Focuses on a specific area of medicine or health care.
Important Documents	
Evidence of Coverage and Benefits	A document given to an insured that describes the benefits, limitations and exclusions of coverage provided by an insurance company. It is the contract between you and the insurance provider.
Explanation of Benefits	An explanation of benefits (commonly referred to as an EOB form) is a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf. An EOB typically describes the service performed including the date of the service, the description and/or insurer's code for the service; the name of the person or place that provided the service; and the name of the patient; the doctor's fee, and what the insurer allows; and the amount the patient is responsible for.

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Insurance Card	Given to you by the health insurance company, this card confirms that you have coverage and provides important information including your health insurance company and important contact information, your member number, type of insurance, and copayment amounts.
Summary of Benefits and Coverage	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 will 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.

Types of Health Care Products

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.
Prescription drugs	Drugs and medications that by law require a prescription.

Source: www.healthcare.gov/glossary

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