## Helpful health insurance marketplace definitions:

**Affordable Care Act** – This is the comprehensive health care reform law enacted in March 2010, as part of the healthcare reform agenda of the Obama administration. The law includes multiple provisions including the expansion of Medicaid eligibility, the establishment of health insurance exchanges and prohibiting health insurers from denying coverage due to pre-existing conditions.

**Benefits** - Health care items or services covered under a health insurance plan.

**Claim** - A request for payment that you or your health care provider submits to your health insurer when you get services you think are covered under your insurance plan.

Coinsurance – The amount that you have to pay for a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay the coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the amount.

**Copayment** - A fixed amount (for example, \$15) that you pay for a covered health care service. The amount can vary by the type of covered health care service.

**Deductible** - The amount that you owe for health care services covered by your health plan, before your health insurance begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you've met your \$1,000 deductible for covered health care services. The deductible may not apply to all services under your health plan.

**Essential health benefits** - A set of health care services that must be covered by certain plans starting in 2014. The Affordable Care Act ensures that health plans offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 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. Insurance policies must cover these benefits in order to participate in the Health Insurance Marketplace, and all Medicaid state plans must cover these services by 2014.

**Excluded services** - Health care services that your health plan does not pay for.

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

**Medicaid** – This is the state-administered health insurance program for low-income families and children, pregnant women, the elderly, and people with disabilities. The Federal government provides a

portion of the funding for Medicaid and sets guidelines for the program. Medicaid varies state by state and may have a different name in your state.

**Medicare** - The 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.

**Minimum essential coverage** - The type of coverage an individual needs to meet the individual responsibility requirement under the Affordable Care Act.

**Navigator** - An individual or organization trained to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased, and their services are free of charge.

**Network** - The facilities and providers that your health insurer or plan has contracted with to provide health care services. Health services with in-network providers usually cost less than out-of-network health services.

**Non - preferred provider** - A provider who does not have a contract with your health insurer or plan to provide services to you. You will pay more to see a non-preferred provider. This is sometimes called an out-of-network provider.

**Open Enrollment** - The period of time during which individuals can enroll in a plan in the Marketplace. For 2014, the Open Enrollment Period is October 1, 2013–March 31, 2014. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events. Individuals can submit an application for health coverage outside of the Marketplace, or apply for Medicaid or CHIP, at any time of the year.

**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, in addition to other costs for services that are not covered.

**Premium** - The monthly, quarterly, or yearly amount that you and/or your employee must pay for your health insurance or plan.

**Qualified health plan** - Under the Affordable Care Act, an insurance plan that is certified by the Health Insurance Marketplace and provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.

**Subsidized coverage** – Financial assistance from programs that help people with low to middle incomes obtain health insurance coverage.

**Total cost estimate for health care coverage** - The total amount you may have to pay for health plan coverage, which is estimated before you actually have the coverage.

For a more comprehensive list of health insurance definitions, go to:

https://www.healthcare.gov/glossary/