



## A

**Affordable Care Act** A new health reform law passed in 2010, aimed at reforming 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. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

**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** The health insurance exchange will include a catastrophic plan with lower premiums. The plan begins to pay only after you've first paid a certain amount for covered services.

**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. You may pay 20% of an allowed service and your plan 80%.

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

**Cost Sharing Subsidies** Federal funds 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 and – if family coverage – the member's dependents.

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

## D

**Deductible** A fixed amount of the eligible 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, other than the member (generally a spouse or child), who receives health care coverage under the member's policy.

**Drug Formulary** A list of commonly prescribed drugs. Not all drugs listed in a plan's prescription drug list are automatically covered under that plan.

## E

**Effective Date** Date on which your health care coverage begins.

**Emergency Medical Care** Services provided for outpatient treatment of an acute medical condition, usually in a hospital.

**Employer Responsibility** Starting in 2014, if an employer with at least 50 full-time equivalent employees doesn't provide affordable health insurance and an employee uses a tax credit to help pay for insurance through a health insurance exchange, the employer must pay a fee to help cover the cost of tax credits.

**Essential Health Benefits** Beginning in 2014, most insurance plans you can choose from – whether you buy on the health insurance exchange or go directly to the insurance company of your choice – will include many essential benefits that are meant to make sure basic health concerns are covered.

**Exclusions** Specific medical conditions or circumstances that are not covered under a particular health plan. In 2014, exclusions go away for most insurance plans.

**Exchange** See health insurance exchange

**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 such as the amount paid, the benefit available, the amount you may owe the provider and the claims appeal process.

## F

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

**Federal Poverty Level (FPL)** A level of income used by the Department of Health and Human Services to determine eligibility for certain programs and benefits. FPL is one factor that will be used to determine the amount of tax credits you may qualify for to offset the cost of purchasing health insurance when purchasing coverage on a health insurance exchange.

## G

**Grandfathered** A health plan that was in place when the new health care law was passed into law. A grandfathered plan is exempt from some requirements of the new law.

**Group Plan** A group of people covered under the same health care policy and identified by their relation to the same employer.

**Guaranteed Coverage** A requirement under the Affordable Care Act that insurers must allow you to enroll in some form of insurance regardless of health status, age, gender or other factors.

---

## H

**Health Insurance Exchange** The new websites where millions of people will shop for, compare and buy health insurance beginning on October 1, 2013. Also called health insurance marketplaces, these sites will be operated by the federal or state government or a combination of the two. Insurance plans will be offered at various coverage and price levels.

**High Risk Pool Plan (State)** These government-offered health plans provide coverage for people with serious health conditions. They are a temporary bridge until the new law's provision ensures that affordable coverage can be obtained by all Americans regardless of a person's health conditions.

---

## I

**Individual Health Insurance Plan** Health care coverage for an individual with no covered dependents.

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

**Individual Mandate** Starting in 2014, the new law requires Americans and legal residents to obtain and maintain health care insurance. You must be enrolled in a health insurance plan that meets basic minimum standards; if not, you may be required to pay a penalty on your annual income tax return. You won't have to pay an assessment if you have very low income and coverage is unaffordable to you, or for other reasons including your religious beliefs.

**Inpatient Services** Services provided when a member/subscriber is registered and treated as a bed patient in a health care facility such as a hospital.

**Insured Person** The person to whom health care coverage has been extended by the contract holder, sometimes referred to as a member/subscriber.

---

## L

**Lifetime Limit** A cap on the total lifetime benefits you may get from your insurance plan, either on all coverage or for a certain condition. Beginning in January 2014, under the new law, lifetime limits are no longer allowed in most cases.

---

## M

**Medicaid** A joint federal and state funded program that provides health care coverage for low-income children and families, and for certain aged and disabled individuals. A provision of the new law significantly expands the program in those states that agree to the expansion.

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

**Member** The person to whom health care coverage has been extended by the contract holder (generally their employer); sometimes referred to as the insured or insured person/subscriber.

---

## N

**Network** The doctors, hospitals and other health care providers that a plan has contracted with to deliver health care services to its members/subscribers.

---

## O

**Open Enrollment Period** The period when you choose from available health insurance plans, usually once a year. The first open enrollment period for purchasing insurance on the health insurance exchanges begins in October 1, 2013 and is extended through March 31, 2014. The next opportunity to enroll would be a year later.

**Out-of-Network** Services not provided in the network of contracted health care professionals and facilities in your health plan.

**Out-of-Pocket Maximum** The maximum amount you have to pay for eligible expenses under your health plan during a defined benefit period.

**Outpatient Services** Treatment that is provided to a patient who is able to return home after care without an overnight stay in a hospital or other inpatient facility.

---

## P

**Preauthorization** The process by which a member or their primary care physician (PCP) notifies the health plan, in advance, of plans for the member to undergo treatment such as a hospital admission or a complex diagnostic test.

**Pre-Existing Condition** A condition, disability or illness that you have been treated for before applying for new health coverage.

**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 copayment or deductible amount too.

**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 who coordinates all your medical care, including hospital admissions and referrals to specialists. Not all plans require a PCP.

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

---

## Q

**Qualified Health Plan** An insurance plan that is certified by an exchange, provides essential health benefits, follows established limits on cost-sharing (deductibles, copayments, and out-of-pocket amounts), and meets other requirements.

---

## T

**Tax Credits** To help people better afford health insurance, those eligible will receive premium tax credits to help defray insurance costs. These credits will make it easier for millions of low and middle-class Americans to pay for health insurance. (also see: cost-sharing subsidies)

**ReformAndYouLL.com**  
**888-809-2810**