Understanding Health Insurance: Frequently Used Terms

Dependent
A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the Affordable Care Act, 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 spouses, children, or partners

Exclusive Provider Organization (EPO) Plan
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).

Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Allowed expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices.

You decide how much to put in an FSA, up to a limit set by your employer. You aren't taxed on this money. If money is left at the end of the year, the employer can offer one of two options (not both):

You get 2.5 more months to spend the left over money.
You can carry over up to $500 to spend the next plan year.
Flexible Spending Accounts are sometimes called Flexible Spending Arrangements.
Learn more about FSA's from the IRS, including allowed expense

Health Savings Account (HSA)
A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account (HSA) to pay for deductibles, copayments, coinsurance, and some other expenses, you may be able to lower your overall health care costs. HSA funds generally may not be used to pay premiums.

While you can use the funds in an HSA at any time to pay for qualified medical expenses, you may contribute to an HSA only if you have a High Deductible Health Plan (HDHP) — generally a health plan (including a Marketplace plan) that only covers preventive services before the deductible.

HSA funds roll over year to year if you don't spend them. An HSA may earn interest or other earnings, which are not taxable.

Some health insurance companies offer HSAs for their HDHPs. Check with your company. You can also open an HSA through some banks and other financial institutions.

Learn about High Deductible Health Plans
See the list of qualifying medical and dental expenses on IRS.gov Publication 502 (PDF)

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 health care costs yourself before the insurance company starts to pay its share (your deductible). A high deductible plan (HDHP) can be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from federal taxes.

Health Maintenance Organization (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't 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.

Medicaid

Insurance program that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Many states have expanded their Medicaid programs to cover all people below certain income levels.

Whether you qualify for Medicaid coverage depends partly on whether your state has expanded its program. Medicaid benefits, and program names, vary somewhat between states.

You can apply anytime. If you qualify, your coverage can begin immediately, any time of year.

Medicare

A federal health insurance program for people 65 and older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
Medicare isn't part of the Health Insurance Marketplace. If you have Medicare coverage you don't have to make any changes. You're considered covered under the health care law.

Medicare Part A

Considered to be original Medicare for Hospital Insurance that generally covers inpatient care in a hospital, skilled nursing facility care (SNF), nursing home care (inpatient care in a skilled nursing facility that's not custodial or long-term care), hospice care, home health care.
Is my test, item, or service covered? - https://www.medicare.gov/coverage

Medicare Part B

Considered to be original Medicare for Medical Insurance covering medically necessary services and preventative services. Medically necessary services are services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.
Is my test, item, or service covered? - https://www.medicare.gov/coverage

Medicare Advantage (Medicare Part C)

A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Part D

A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare 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.

Open Enrollment Period

The yearly period when people can enroll in a health insurance plan. Open Enrollment for 2020 is over, but you may still be able to enroll in a Marketplace health insurance plan for 2020 if you qualify for a Special Enrollment Period.

You're eligible if you have certain life events, like getting married, having a baby, or losing other health coverage.

- Job-based plans may have different Open Enrollment Periods. Check with your employer.
- You can apply and enroll in Medicaid or the Children's Health Insurance Program (CHIP) any time of year

Pre-Existing Condition

A health problem, like asthma, diabetes, or cancer, you had before the date that new health coverage starts. Insurance companies can't refuse to cover treatment for your pre-existing condition or charge you more.

Pre-Existing Condition Exclusion Period (Job-based Coverage)

The time period during which a health plan won't pay for care relating to a pre-existing condition. Under a job-based plan, this cannot exceed 12 months for a regular enrollee or 18 months for a late-enrollee.

Point of Service (POS) Plans

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 also require 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, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Qualifying Life Event (QLE)

A change in your situation — like getting married, having a baby, or losing health coverage — that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the yearly Open Enrollment Period.

Special Enrollment Period (SEP)

A time outside the yearly Open Enrollment Period when you can sign up for health insurance. You qualify for a Special Enrollment Period if you've had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child.

Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the event to enroll in a plan. If you miss your Special Enrollment Period window, you may have to wait until the next Open Enrollment Period to apply.

You can enroll in Medicaid or the Children's Health Insurance Program (CHIP) any time of year, if you're eligible, whether you qualify for a Special Enrollment Period or not.

Job-based plans must provide a Special Enrollment Period of at least 30 days.

Summary of Benefits and Coverage (SBC)

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'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.

Uncompensated Care

Health care or services provided by hospitals or health care providers that don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.