nystateofhealth
The Official Health Plan Marketplace

List of Insurance Terms and Definitions for Uniform Translation

Term	Definition
actuarial value	The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.
Affordable Care Act	The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.
allowed charge	The maximum amount that an insurer will consider to pay for a service, including any amount that the patient will be responsible for paying. For in-network providers, the allowed charge is based on the contracts with the providers. For out-of-network providers, the allowed charges may be: • the same as for in-network providers, • based on a percentage of the amount that Medicare would pay for the same services, or • Usual, Customary and Reasonable (UCR) charges, an amount that your plan determines is reasonable for that service in your local area.
amount allowed	Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.
coverage appeal	A request for your health insurer or plan to review a decision or a grievance again.
complaint	If you feel a health care provider has discriminated against you (or someone else) based on race, national origin, disability, or age, you may file a civil rights complaint.

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co-payments	A fixed amount (for example, $15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.
co-insurance	Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay 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 allowed amount.
cost sharing reductions	A discount that lowers the amount you have to pay out-of-pocket for deductibles, coinsurance, and copayments. You can get this reduction if you get health insurance through the Marketplace, your income is below a certain level, and you choose a health plan from the Silver plan category. If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.
covered services	The medical services, procedures, prescription drugs and other healthcare services that your insurer pays for under your plan. Keep in mind that not all care is covered. For instance, some plans will not pay for medications that are available over the counter. And, even if a service is covered, you may still need to pay a co-payment or co-insurance, request pre-authorization, or get a referral from your primary care physician before your insurer will pay. Your policy should contain a detailed list of what is and is not covered.
date of service	The date that you receive a health care service or visit a health care provider or facility.
deductible	The amount you owe for health care services your health insurance or plan covers before your health insurance or plan 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 subject to the deductible. The deductible may not apply to all services.
denial	Decision by a health insurance company not to pay for a service, test or treatment because it is not covered under your health insurance plan or not considered medically necessary according to

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	the health plans benefits and rules.
discontinuance	Action by a health insurance company to stop offering a particular health insurance plan.
emergency medical condition	An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.
exclusion	Health care services that your health insurance or plan doesn't pay for or cover.
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).
exemption	In relation to the Affordable Care Act, an exemption refers to a waiver that certain people in specific situations can get that means they are not required to have health insurance. For a list of circumstances that may qualify for an exemption, visit healthcare.gov.
explanation of benefits	Your insurer will provide you with an explanation of benefits (EOB) after you have submitted a healthcare claim to your insurer or after a provider has submitted a claim to your insurer on your behalf. The EOB will include a detailed explanation of how your insurer/administrator determined the amount of reimbursement it made to your provider or to you for a particular medical service. The EOB will also include information on how to appeal or challenge your insurer's reimbursement decision. Note that you may not receive an EOB for care that you have received from a provider or facility that is in your insurer's network if there is no required payment from you for those services.
financial assistance	The dollar amount of a tax credit someone gets to use toward their health insurance premium that reduces the cost of health insurance, available only through NY State of Health.
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.
grandfathered	As used in connection with the Affordable Care Act: Exempt from certain provisions of this law.
health care reform	See Affordable Care Act
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

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	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.
Health Savings Account (HSA)	A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. If an employer chooses, employees may carry over up to $500 into the next calendar year.
in network	Pertains to treatment from doctors, clinics, health centers, hospitals, medical practices and other providers with whom your plan has an agreement to provide care for its members. Usually, you will pay less out of your own pocket when you receive treatment from in-network providers.
insurance	A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.
Marketplace	A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance.
metal tier	Health plans offered in the Marketplace will fall into categories called metal tiers. The metal tiers are bronze, silver, gold and platinum, and are associated with an actuarial value. Actuarial value is the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, the consumer would be responsible for, on average, 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy. Platinum provides the highest level of coverage, followed by

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	gold, silver and bronze.
not medically necessary	Health care services or supplies that are determined not needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
Obamacare	The Affordable Care Act is sometimes referred to as Obamacare.
out of network (OON)	Pertains to treatment from doctors, clinics, health centers, hospitals, medical practices and other providers that do not have an agreement with your health insurer to provide care to its members. You typically will pay more out of your own pocket when you receive treatment from out-of-network providers.
out of network (OON) benefit	Benefit plan coverage for services provided by doctors and other healthcare professionals who are not under a contract with your health plan.
out of pocket cost	Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.
out of pocket maximum	The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit. In Medicaid and CHIP, the limit includes premiums. Even at the lowest metal tier, the most a person would pay out of pocket is $6,350 (the most a family would pay out of pocket is $12,700). Other metal tiers have lower out of pocket costs.
participating provider	A physician, dentist or other healthcare professional who or a hospital or healthcare facility that contracts with a health insurer to provide services to its members at a specific fee amount.
Point of Service (POS) Plan	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.

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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.
premium	The amount that must be paid for your health insurance or plan. You or you and your employer usually pay it monthly, quarterly or yearly.
Qualified Health Plan	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.
referral	A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.
self-insured	Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.
Small Business Marketplace	The Small Business Marketplace is part of NY State of Health and offers low-cost health plans to small businesses with 50 or fewer employees.
tax credits	Individuals and small business owners may qualify for tax credits that will reduce the cost of health insurance. These tax credits only are available through NY State of Health.
The Official Health Plan Marketplace	This is the tagline for NY State of Health. New Yorkers can shop, compare and enroll in low-cost, affordable health insurance plans through NY State of Health.
utilization review	The process of examining the health care services a patient has received.

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