
A Guide to

Health Insurance Terminology

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GoodRx Health

General Terms

Advance premium tax credit

This **special subsidy from the government** helps you pay less for health insurance every month. To qualify, you must enroll in a health plan through the Affordable Care Act marketplace. The government then pays a portion of your health insurance premium each month. However, it's your responsibility to pay any amount left over.

Affordable Care Act

This is also known as the **Patient Protection and Affordable Care Act**. It is a 2010 law, often referred to as Obamacare, which aims to make health insurance more accessible and affordable.

Bronze health plan

This plan is known for having the **lowest monthly premiums** among the four “metal” tiers of Affordable Care Act health plans. Bronze health plans have higher out-of-pocket costs when you receive medical care, however. The insurance company typically pays about 60% of the costs and you pay the remaining 40%.

Cafeteria plan

This is a customized benefits package set up and **maintained by your employer**. It allows you to pick and choose the benefits you want, similar to choosing food items in a cafeteria.

It is also known as a [Section 125 plan](#) of the IRS tax code, which allows you to receive certain benefits pretax such as group-term life insurance coverage, health savings accounts, and health benefits. Participants must have an option to select one taxable benefit, such as cash, and one qualified benefit (non-taxable) like a health savings account.

Children's Health Insurance Program (CHIP)

This program provides low-cost health coverage for children in families who don't qualify for Medicaid because their incomes are too high. CHIP also covers pregnant women in certain states. All states provide a version of CHIP, but the name of the program can vary by state.

ADDITIONAL RESOURCES

1. [How Does the Premium Tax Credit for Health Insurance Work?](#)
2. [The Affordable Care Act \(ACA\): Your GoodRx Guide](#)
3. [What Are the Four 'Metal' Tiers of Affordable Care Act Health Plans?](#)
4. [What Does the Children's Health Insurance Program \(CHIP\) Do?](#)

Claim

A claim is a **payment request** sent by your healthcare provider to your health insurance company. It is typically in the form of an itemized bill that lists all the medical services provided to you. Claim dates can range from one day of service at your doctor's office to an extended hospital stay.

COBRA

COBRA is a health insurance program that offers eligible employees and their dependents extended health insurance coverage for the plan they're on, in the event that they lose their job or their hours are reduced. It stands for the **Consolidated Omnibus Budget Reconciliation Act of 1985**, which is the law that first introduced COBRA insurance.

Coinsurance

This is the **percentage you'll pay** for covered health services after you've met your annual deductible. Many plans offer 80/20 coinsurance, covering 80% of the cost of a service. That means you'll pay 20%. So if you visit the doctor and it costs \$100, you'll pay \$20.

Copayment

More commonly referred to as a **copay**, this is a set amount you'll pay for covered health services once you've met your deductible. Copays can vary depending on whether it's for a medication, a visit to the doctor, or a lab test. If your insurance plan states that your copay for visits to the doctor is \$20, that's how much you'll pay for that care.

Deductible

The amount you'll pay out of pocket for covered health services before your insurance plan starts to pay. For example, if your deductible is \$2,500, you'll pay \$2,500 towards covered services **before your insurance starts** to pay. After that, you'll typically [only pay a copay or coinsurance for covered care](#).

Early and Periodic Screening, Diagnostic, and Treatment Services

These health services are available for children under age 21 who are enrolled in Medicaid. [EPSDT](#) provides screening, vision, dental, hearing, and other necessary healthcare services.



ADDITIONAL RESOURCES

1. [Health Insurance 101: What Is a Claim?](#)
2. [What Is COBRA Health Insurance?](#)
3. [What Is Coinsurance, and When Do You Pay it?](#)
4. [How to Choose Your Health Insurance Plan](#)

Exclusive provider organization plan

This is a managed-care health insurance plan that has features of both a health maintenance organization (HMO) and a preferred provider organization (PPO). EPOs **rely on in-network providers** and may not require you to have a primary care physician or get specialist referrals. You'll also have to pay out of pocket to see a provider who's not part of the EPO, except during an emergency.

Explanation of benefits

This is a document you receive from your health plan after using your medical insurance. It breaks down how much you and your health plan are each responsible for paying. An EOB is not a bill. It gives you a heads-up about what to expect when the actual bill arrives from your healthcare provider. It includes payment details, benefits, discounts, and denial reasons.

Family and Medical Leave Act

This law provides eligible employees with up to 12 weeks off work in a 12-month period without pay. FMLA applies to a leave for specific family or medical reasons, and you can still use your employer's health plan.

Federal poverty level

These income numbers are provided annually by the Department of Health and Human Services. Your poverty level **determines your eligibility for government benefits** and programs like Medicaid and CHIP.

Flexible spending account (FSA)

This is an employer-sponsored account that allows you to pay for out-of-pocket healthcare costs with tax-free dollars. Money is set aside from your paycheck and placed into this account before taxes are deducted from your income. You can typically use FSA funds for copayments, deductibles, prescription medications, and medical devices.

Formulary

This is a **list of generic and brand-name prescription medications** that your health insurance covers.

Formularies vary by insurance plan and can change year to year. If you are planning on switching health insurance plans, you'll want to check that your current medications are on the new insurer's formulary. If they're not, you can work with your healthcare provider to request a formulary exception.

ADDITIONAL RESOURCES

1. [What Is an Exclusive Provider Organization \(EPO\) Healthcare Plan?](#)
2. [What's an EOB \(and What Should You Do If You Get One\)?](#)
3. [What Is the Family and Medical Leave Act \(FMLA\), and How Do I Apply for Its Protections?](#)
4. [What Is an FSA and How Does It Work?](#)
5. [A Guide to Medication Formularies](#)

Generic medications

Generic drugs have the **same active ingredients**, quality, and effect as brand-name drugs but are far less expensive. The FDA also checks them to ensure they're safe and effective. However, not all drugs have a generic version.

Gold health plan

This is one of the four metal tiers of Affordable Care Act plans. This plan typically offers more comprehensive coverage compared to lower-tier plans like bronze or silver. With a gold plan, you'll **generally pay higher monthly premiums** but you'll also pay lower out-of-pocket costs when receiving medical care.

Group health plan

Group health plans are **typically employer-sponsored** health plans that cover employees and their dependents.

ADDITIONAL RESOURCES

1. [Biosimilar vs. Generic Drugs: 4 Similarities and Differences You Should Know](#)
2. [What Are the Four 'Metal' Tiers of Affordable Care Act Health Plans?](#)
3. [Employer-Sponsored Health Insurance: Your GoodRx Guide](#)
4. [What Is an HMO? Comparing Pros and Cons](#)
5. [How Do Health Reimbursement Arrangements \(HRAs\) work?](#)
6. [What Is a Health Savings Account, and How Does It Work?](#)

Health insurance marketplace

This **online platform**, also known as the health insurance exchange, was established under the Affordable Care Act. The [health insurance marketplace](#) helps you find, compare, and buy health insurance plans from different companies.

Health maintenance organization (HMO)

An HMO stands for "health maintenance organization" and is a type of health insurance plan. HMOs work with specific doctors and hospitals to be part of their network of medical providers. These plans **typically don't cover any care from a provider outside of their network**, except in the case of emergencies.

Health reimbursement arrangement (HRA)

This is an employer-funded benefit plan that helps employees pay for certain medical expenses. An HRA allows employers to reimburse employees for qualified medical expenses on a **tax-free** basis.

Health savings account (HSA)

An HSA is a tax-advantaged savings account that can be used for qualified healthcare expenses. Similar to an FSA, funds added to an HSA are not subject to income tax. You can also invest the funds in your HSA and roll the funds over every year. However, you can only make contributions to an HSA if you are currently enrolled in a high-deductible health plan.

High deductible health plan (HDHP)

The amount of money you are responsible for paying out of pocket before your insurance begins paying is higher with this type of plan. However, **monthly premiums with HDHPs are typically lower** than those of other plans. HDHPs vary based on the type of plan.

Home healthcare

A person homebound with an illness or injury may receive this service. Home healthcare services can include wound care, injections, or health monitoring. It's designed to help you **manage your health while maintaining independence**.

In-network

This refers to care or providers who are **part of your insurance plan's** contracted network. Services from in-network providers typically cost less compared to services from out-of-network providers.

Inpatient care

Inpatient care requires a **hospital stay** and continuous supervision by a healthcare provider. This could be for care after a minor surgery or for a serious ongoing health condition.

Job-based health plan

This is also known as a group health plan. These are **employer-sponsored health plans** where your employer chooses which medical services the plan will cover. Your employer will split the cost of healthcare expenses with you.

Long-term care

This is a [range of services](#) provided to **people who need help performing basic activities** of daily living like eating or bathing. People can receive long-term care at home or in facilities like nursing homes. Most health insurance plans, including Medicare, don't typically cover these services.

Medicaid

Medicaid provides **free or low-cost health insurance to certain groups** including low-income families and children, pregnant women, adults over the age of 65, and people with disabilities. The federal government provides a portion of the funding and creates the guidelines, rules, and restrictions. Medicaid programs and what they're called may vary from state to state.

Medically necessary

This refers to health services that meet accepted standards of medicine and are needed to treat or diagnose a condition, injury, or illness. In the event that a health service you need is not covered by your health insurance, your provider can **request an exception** by explaining that the care is "medically necessary."

ADDITIONAL RESOURCES

1. [High-Deductible Health Plans: Pros, Cons, and FAQs](#)
2. [Does Medicare Cover Home Healthcare?](#)
3. [Medicaid: Your GoodRx Guide](#)

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Medicare Part A

Part A covers **inpatient hospital stays**, skilled nursing facility care, hospice care, and certain home care services. Part A is available without monthly premiums if you are over the age of 65 and you or your spouse paid Medicare taxes for at least 10 years.

Medicare Part B

Part B covers **outpatient services** like doctor visits, lab tests, screenings, preventive services, medical equipment, and ambulance transportation. It requires a monthly premium.

Medicare Part C (Medicare Advantage)

More commonly referred to as **Medicare Advantage**. If you are enrolled in Medicare Parts A and B, you can enroll in Medicare Advantage for **additional coverage**. This gives you the opportunity to select a private HMO or PPO insurance plan approved by Medicare. Most, but not all, Medicare Advantage plans also include prescription medication coverage. These plans carry additional costs that will depend on the type of private plan you select.

Medicare Part D

This Medicare plan **covers some of your prescription medication costs**. The amount you'll pay for this additional coverage depends on a range of factors.

Medicare prescription drug 'donut hole'

The period in which your prescription drug plan **will not help with medication costs**. This can occur after you and your plan have already paid a certain amount for medications. Depending on your needs, you might not even reach the donut hole.

ADDITIONAL RESOURCES

1. [Medicaid: Your GoodRx Guide](#)
2. [Medicare Prescription Drug Coverage: How to Compare Plans and Save](#)



Additional Terms

Network

The providers, hospitals, and suppliers your health insurer has **contracted with** to deliver healthcare services.

Open enrollment

The period of time each year when you can enroll in a new health insurance plan. You can typically sign up for health insurance through the Affordable Care Act marketplace from [November 1 to January 15](#). But if you have a job-based plan, the dates might differ, so check with your employer.

Out-of-network

This refers to care or providers who are **not part of your insurance** plan's contracted network.

Out-of-pocket costs

Out-of-pocket costs can include deductibles, coinsurance, and copays that are **not reimbursed** by your health insurance plan.

Out-of-pocket limit (or maximum)

This is the maximum amount you'll pay out of pocket in a given year. For 2023, the federally enforced limits are [\\$9,100 for individuals and \\$18,200 for families](#). Every health plan has its own out-of-pocket maximums, which may not be as high as the federal limits.

Outpatient care

This type of care **does not require an overnight** stay in the hospital or healthcare facility. It's typically a service or procedure you can have within a few hours and then return home the same day. For instance, once you receive an X-ray, MRI, or blood work at a laboratory or diagnostic center, you are free to leave the facility.

Platinum health plan

This is one of the four metal categories of health plans offered through the Affordable Care Act. These plans have the lowest costs when you receive care, but have the **highest monthly premiums**. The insurance company typically pays about 90% of the costs and you pay the remaining 10% for platinum plans.

ADDITIONAL RESOURCES

1. [What Are Out-of-Pocket Healthcare Costs?](#)
2. [How Much Does an MRI Cost?](#)
3. [What Are the Four 'Metal' Tiers of Affordable Care Act Health Plans?](#)

Point-of-service plan (POS)

A POS is a managed-care health plan that offers lower costs when you use in-network providers. Similar to an HMO, you must have a primary doctor. And a referral is required to see a specialist. This plan does give you the flexibility to use out-of-network providers. But it will cost you more. Also, with a POS, you will likely have copayments but no deductible.

Pre-existing condition

This is a **chronic health issue you already had** before your health insurance coverage started. Under the [Affordable Care Act](#), insurers can't deny coverage or increase your costs due to a pre-existing condition. That also includes pregnancy.

Preferred provider organization (PPO)

A preferred provider organization (PPO) is a type of health insurance plan. PPOs have a **network of participating providers that you'll pay less to visit**. You can visit facilities, doctors, and providers outside of the network for a slightly higher cost.

Premium

A premium is the **recurring payment** to your insurance company that keeps your health insurance active. It is typically paid monthly by you and your employer. But payments can also be made quarterly or yearly. The premium may include certain benefits, such as free annual checkups. But it does not cover all your healthcare costs, such as deductibles, copayments, and coinsurance.

Premium tax credit (subsidy)

This tax credit is **available to qualified individuals** who enroll in a health insurance plan through the Affordable Care Act marketplace. Your potential tax credit is based on many factors, including your estimated income and household size. The premium tax credit can reduce your tax bill at the end of the year.

Preventive services

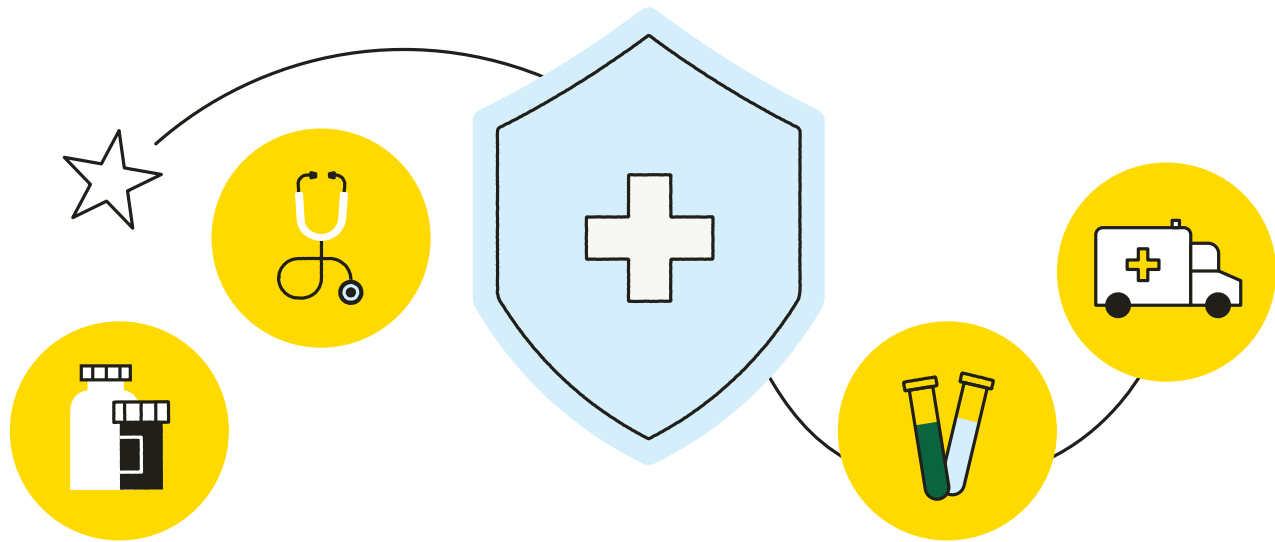
These are routine health assessments to identify or prevent potential health problems. They often include screenings to detect hidden health issues, lab work, and checkups with your doctor.

Prior authorization

Prior authorization is approval from your health plan before you receive certain medications, tests, or treatments. This is sometimes known as preauthorization. Your health insurer determines if the services are medically necessary, except during an emergency. Depending on your benefits, some services may not be covered without [pre-approval](#).

ADDITIONAL RESOURCES

1. [What Is a Point-of-Service \(POS\) Health Plan, and How Is It Different From a PPO or HMO?](#)
2. [What Is PPO Insurance?](#)



Silver health plan

This Affordable Care Act plan is referred to as the “benchmark” plan because of its **moderate costs** when you need care and moderate monthly premiums. The insurance company typically pays about 70% of the costs and you pay the remaining 30% for silver plans.

Skilled nursing care

This type of care involves **licensed professionals**, like nurses and therapists, who treat and manage residents’ medical conditions.

Special enrollment period

A special enrollment period allows you to enroll in or make changes to your health plan outside of the regular enrollment period. Examples of **qualifying life events** that may trigger a special enrollment period include getting married or having a baby.

Summary of benefits and coverage (SBC)

The SBC is a **document that provides essential information** about a health insurance plan, including costs, benefits, covered services, and exclusions.

ADDITIONAL RESOURCES

1. [What Are the Four ‘Metal’ Tiers of Affordable Care Act Health Plans?](#)
2. [7 Qualifying Life Events for Health Insurance](#)
3. [A Guide to Your Summary of Benefits and Coverage \(SBC\)](#)