Defining Healthcare Insurance

A GLOSSARY OF TERMS

washington healthplanfinder

click. compare. covered.

A

Affordable Care Act (ACA)

The health care reform law passed in March 2010. The law was passed in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was changed by the Health Care and Education Reconciliation Act on March 30, 2010. The final version of the law is called the Affordable Care Act.

agent

An agent (**broker** or producer) is a person or business who can help you enroll in a health plan through the Healthplanfinder online marketplace. An agent or broker can also help you apply for tax credits. If you qualify, tax credits provide financial help to cut the cost of your health care coverage. They can offer advice on which health plan best fits your needs and your budget. They are also licensed and regulated by states. Agents and brokers most often get paid by health plans for enrolling a consumer into a health plan. Some agents and brokers may only be able to sell plans from specific health insurers.

Alien Emergency Medical (AEM) program

To be able to get Alien Emergency Medical, a person must be:

- a parent with a dependent child,
- an adult with a disability,
- a blind or aged (65 or older) adult,
- or a child under age 19,
- ineligible for Medicaid due to citizenship status or Social Security Number requirements,
- experiencing a qualifying medical emergency.

Eligibility for Alien Emergency Medical services is determined by the Specialized Medical Unit in the Department of Social and Health Services. For more information, call 1-877-501-2233.

allowed amount

The highest dollar amount your health insurance plan will pay for covered health care services. This may also 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. Your provider can only charge more than the allowed amount if they are outside of your health plan's network. If an out-of-network provider charges more than the payment allowance, you may have to pay the difference. See also **balance billing**.

annual deductible combined

The total amount that family members on a plan must pay out-of-pocket for health care or prescription drugs ***before*** the health plan begins to pay. This usually refers to plans that are eligible for Health Savings Accounts (HSAs).

annual limit

A cap on the benefits your insurance company will pay in a calendar year while you're enrolled in a particular health insurance plan. These caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

appeal

A request for your health insurer or plan to review a decision or a grievance again.

Apple Health

See also **Medicaid**. A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and low-income adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their programs, so Medicaid varies state by state. In Washington State, the Medicaid program is called **Apple Health**.

The health plans providing Apple Health coverage are: Amerigroup Washington, Inc. (AMG), Community Health Plan of Washington (CHPW), Coordinated Care Corporation (CCC), Molina Healthcare of Washington (MHC), and United Health Care Community Plan (UHC).

You can apply for Apple Health at any time.

attest/attestation

When you apply for health coverage through the Healthplanfinder marketplace, you're required to agree (or "attest") to the truth of the information provided by signing the application.

Authorized Representative (AREP)

Someone you choose to act on your behalf with the Healthplanfinder marketplace, such as a family member or other trusted person. An Authorized Representative may be any adult who is aware of your circumstances and can act on your behalf to apply for, or maintain your benefits, including your health insurance plan. Authorized Representatives are not authorized to receive personal health information unless they also have other qualifications, like power of attorney or guardianship status.

Some authorized representatives may have legal authority to act on your behalf.

B

balance billing

A balance billing is the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider may not "balance bill" you for covered services.

benefits

The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

benefit year

A year of benefits coverage under an individual health insurance plan. The benefit year for plans bought inside or outside the Healthplanfinder marketplace begins January 1 and ends December 31 of the same year. Your coverage ends December 31, even if your coverage started after January 1. Any changes to a plan's benefits or rates are made at the beginning of the calendar year.

brand name (drug)

A drug sold by a drug company under a specific name or trademark and protected by a patent. Brand name drugs may be available by prescription or over the counter.

broker

A broker (**agent** or producer) is a person or business who can help you apply for help paying for coverage and enroll in a Qualified Health Plan (QHP) through the Healthplanfinder marketplace. They can recommend which plan you should enroll in. They are also licensed and regulated by Washington State and typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer's plans. Some brokers may only be able to sell plans from specific health insurers.

Bronze Health Plan

Plans in the Healthplanfinder marketplace are available in 4 categories — **Bronze**, Silver, Gold and Platinum — based on the percentage that each plan pays of the average overall cost of providing essential health benefits to members. *The plan category you choose affects the total amount you'll likely spend for essential health benefits during the year.* The percentages the plans will spend, on average, are **60% (Bronze)**, 70% (Silver), 80% (Gold), and 90% (Platinum). This is not the same as co-insurance, in which you pay a specific percentage of the cost of a specific service.

care coordination

The organization of your treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care.

carrier

A health insurance plan or organization.

catastrophic health plan

A catastrophic health plan meets all the requirements of other Qualified Health Plans (QHPs) but does not cover any benefits other than 3 primary care visits per year before the plan's deductible is met. The premium amount you pay for this plan is generally lower than for other QHPs, but the out-of-pocket costs for deductibles, co-payments, and co-insurance are generally higher. To qualify for a catastrophic plan, you must be under 30 years old OR get a **hardship exemption** because the Healthplanfinder marketplace determined that you're unable to afford health coverage.

Certified Application Counselor

An individual (affiliated with a designated organization) who is trained to help consumers, small businesses, and their employees as they look for health coverage options through the Healthplanfinder marketplace. These counselors can also help consumers complete eligibility and enrollment forms. Their services are free to consumers. Certified Applicant Counselors mostly work in hospitals.

Children's Health Insurance Program (CHIP)

A ***low-premium*** insurance program jointly funded by the state and federal government that provides health coverage to low-income children. In Washington State, CHIP is known as **Children's Apple Health**.

chronic disease management

An integrated care approach to managing illness that includes screenings, check-ups, monitoring and coordinating treatment, and patient education. If you have a chronic disease, it can improve your quality of life and reduce your health care costs by preventing or minimizing the effects of that disease.

claim

A request for payment that you or your health care provider submits to your health insurer when you get health care items or services you think are covered .

COBRA

A federal law that may allow you to temporarily keep health coverage in some situations: 1) after your employment ends; 2) if you lose coverage as a dependent of the covered employee; or 3) another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

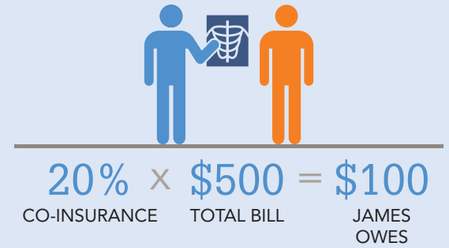
co-insurance

Your share of the costs of a covered health service. You start to pay co-insurance after you have paid your health plan's **deductible**. Your plan pays the rest. Some health plans pharmacy benefits are set up so you pay coinsurance instead of a copay until your deductible is met.

HOW IT WORKS >

James has paid his health plan deductible. He gets a bill for $500 dollars for a health test. His health plan will pay 80% of the bill or $400 dollars. As part of his co-insurance James will pay 20% of the bill or $100 dollars.

Amount of co-insurance varies by health plan.



community rating

A method of setting **premiums** so that risk is spread evenly across the community, with all individuals in a community region paying the same premium rate regardless of their health status and other factors such as age, gender, and other characteristics.

A variation of community rating is **adjusted community rating** where health insurance plans cannot vary their rates based on health status but can use other factors, such as age and smoking-status. However, the Affordable Care Act (ACA) limits this by not allowing health insurance plans to charge an older adult more than 3 times the rate of a younger person. Washington currently uses adjusted community rating.

complication of pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Maternity and newborn care for women who have complications of pregnancy are now **Essential Health Benefits**. Morning sickness and non-emergency cesarean sections are not covered as complications of pregnancy.

conditional eligible

If you submit an application through Healthplanfinder without necessary or verified documentation, *and you are otherwise eligible*, you will be determined **conditionally eligible**. You have ***90 days from submission*** to verify your enrolled status and provide the required documentation.

coordination of benefits

The process used to decide who pays first when 2 or more health insurance plans are responsible for paying the same medical claim.

co-pay or co-payment

A fixed amount that you pay for a covered health care service, such as a regular doctor's visit or prescription. Co-pays are paid at the time of service and do not apply toward your **deductible** costs.

HOW IT WORKS

Thomas has high blood pressure and visits his primary care doctor every 3 months. His health plan calls for a co-pay of $20 for doctor visits. Thomas pays his co-pay for each visit to the doctor.

Amount of co-pay varies by health plan.

cost sharing

The share of costs for care covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, co-insurance, and copayments, or similar charges. It does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. In Medicaid (Apple Health) and CHIP (Children's Apple Health), cost sharing also includes premiums.

cost sharing reduction

A discount that lowers the amount you pay deductibles, co-insurance, and copayments and other out-of-pocket expenses. You can get this reduction if you get health insurance through *Washington Healthplanfinder* if your income is below 250% FPL (**federal poverty level**), AND you choose a health plan from the **Silver** plan category or higher (see **health plan categories**). If you are a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits on any plan.

D

deductible

The amount you pay in a calendar year ***before*** your health plan starts to pay for some of your care. You pay 100% of your health care costs until you reach the deductible amount. Co-insurance cost may still apply. High deductible insurance plans often have lower monthly premium costs and higher out-of-pocket costs. Low deductible plans often have higher premium cost and lower out-of-pocket costs.

HOW IT WORKS

Marcus has a yearly $2,000 deductible. He has a stay in the hospital that costs $10,000. Marcus has to pay his deductible before his health plan pays any of the costs.

Deductibles and other costs vary by health plan.

dental coverage

Benefits that help pay for the cost of visits to a dentist for basic or preventive services, like teeth cleaning, X-rays, and fillings. Children under 19 are required to be enrolled in a Pediatric Dental Plan. Due to the Affordable Care Act (ACA), all health plans sold through the Healthplanfinder marketplace must include dental services for children under age 19. In addition, pediatric dental coverage is available from "stand-alone" dental plans on the Healthplanfinder marketplace as well. QHPs do not have to include adult dental coverage.

If adult dental coverage is important to you, check the details of any plan you're considering to see if it is included.

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 (ACA), individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents.

dependent coverage

Health insurance coverage for family members of the health plan policyholder, such as spouses, children, or partners.

drug list

A list of the prescription drugs covered by your health plan. Based on the design of your plan, you may pay a co-pay, co-insurance or the full cost of the drugs until your deductible is met. Also called a **formulary**.

durable medical equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage may include: oxygen equipment, wheelchairs, crutches, and blood testing strips for diabetics.

E

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)

A term that refers to the comprehensive set of benefits covered for children up to age 19 in Medicaid (**Apple Health**).

eligible immigration status

An immigration status that is considered eligible for health coverage through the Healthplanfinder marketplace. The rules for eligible immigration status may differ in different insurance affordability programs.

emergency medical condition

An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an emergency medical condition.

Employer Shared Responsibility Payment (ESRP)

The Affordable Care Act (ACA) requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to their full-time employees (and their dependents) that meets minimum standards set by the Affordable Care Act, or to make a tax payment called the ESRP.

employer or union retiree plans

Plans that provide health and/or drug coverage to former employees or members, and, in some cases, their families. These plans are offered to people through their (or a spouse's) former employer or employee organization. Many of these plans are not legally required to meet all provisions of the Affordable Care Act, including providing coverage for children up to age 26.

essential health benefits

A set of 10 health care services that all plans must cover. Some benefits are free. Some may have co-pays and co-insurance.

1. Doctor visits and hospital stays
2. Trips to the emergency room
3. Care before and after your baby is born
4. Mental health and substance use treatment services
5. Prescription drugs
6. Services and devices to help you recover if you get injured, or have a disability or chronic condition
7. Lab tests
8. Preventive services including counseling, screenings and vaccination
9. Management of a chronic disease, like diabetes or asthma
10. Pediatric care

HOW IT WORKS

Now all health plans must include hospitalization benefits. For details call *Washington Healthplanfinder* at 1-855-WAFINDER (1-855-923-4633) or call your health plan.

GET HELP FROM FRIENDLY EXPERTS

excluded services

Health care services that your health insurance plan does not pay for or cover.

Exclusive Provider Organization (EPO) Plan

A health insurance plan that only covers services if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

external review

A review of a plan's decision to deny coverage for, or payment of, a service by an independent third party. If the plan denies an appeal, an external review can be requested. In urgent situations, an external review may be requested even if the internal appeals process is not yet completed. External review is available when: the plan denies treatment based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; the plan determines that the care is experimental and/or investigational; or for cancellations of coverage. An external review either upholds the plan's decision or overturns all or some of the plan's decision. The health plan must accept the decision of an external review.

F

Family and Medical Leave Act (FMLA)

A federal law that guarantees up to 12 weeks of job-protected leave for certain employees when they need to take time off due to serious illness or disability, to have or adopt a child, or to care for another family member. When on leave under FMLA, you can continue coverage under your job-based plan. Talk to your Human Resources (HR) department at work for more information.

Federal Poverty Level (FPL)

A measure of income level issued annually by the Department of Health and Human Services (DHHS). Federal poverty levels are used to determine your eligibility for certain programs and benefits, including Apple Health (Medicaid).

FAMILY SIZE	2014 FEDERAL POVERTY LEVEL (100% FPL)	MEDICAID ELIGIBILITY (138% OF FPL)	PREMIUM SUBSIDY THRESHOLD (400% OF FPL)
Individual	$11,670	$16,105	$46,680
2	$15,730	$21,707	$62,920
3	$19,790	$27,310	$79,160
4	$23,850	$32,913	$95,400
5	$27,910	$38,516	$111,640
6	$31,970	$44,119	$127,880
7	$36,030	$49,721	$144,120
8	$40,090	$55,324	$160,360

The amounts listed above are 2014 Federal Poverty Level numbers. These numbers are subject to change.

Cost-sharing reduction subsidies are also available depending on income. See a local health insurance Navigator or Insurance Broker for free for more information.

Federally Qualified Health Centers (FQHC)

Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally Qualified Health Centers provide primary care services regardless of your ability to pay. Services are provided on a sliding scale fee, based on your ability to pay.

fee (penalty)

If someone does not have a health insurance plan that qualifies as minimum essential coverage, he or she may have to pay a fee. The fee increases every year: from **1% of income** (or $95 per adult, ***whichever is higher***) in 2014 to **2.5% of income** (or $695 per adult) in 2016. The fee for children is half of the adult amount. The fee is paid on your federal income tax form when you pay your taxes. People with very low incomes and others may be eligible for waivers.

fee for service (FFS)

A method by which doctors and other health care providers are paid for ***each service*** performed. Examples of services include tests, office visits, or procedures. The fee for service method is often compared to the managed care model in which beneficiaries pay a set premium in return for care from a defined network of providers.

Flexible Benefits Plan

A benefit program that offers employees a choice of various benefits including cash, life insurance, health insurance, vacations, retirement plans, and child care. Although a common set of core benefits may be required, you can choose how your remaining benefit dollars are allocated to each type of benefit from the total amount promised by the employer. Sometimes you can contribute more dollars to get additional coverage. Also known as a Cafeteria plan or IRS 125 Plan.

Flexible Spending Account (FSA)

An arrangement you set up through your employer to pay for many of your out-of-pocket medical expenses with tax-free dollars. These expenses include insurance co-payments and deductibles, and qualified prescription drugs, insulin and medical devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. You don't have to pay taxes on this money. Your employer's plan sets a limit on the amount you can put into an FSA each year.

There is no carryover of FSA funds. This means that any FSA funds you don't spend by the end of the plan year cannot be used for expenses in the next year. An exception is if your employer's FSA plan permits you to use unused FSA funds for expenses incurred during a grace period of up to 2.5 months after the end of the FSA plan year.

(Note: Flexible Spending Accounts are sometimes called Flexible Spending Arrangements.)

formulary

A list of the prescription drugs your insurance plan will pay for, fully or partially. Depending on your plan, you may pay a co-pay for these drugs.

HOW IT WORKS

George goes to the drug store to fill a new prescription. George has the pharmacist check his health plan's formulary list. His health plan will pay for the medication. George pays a $20 co-pay for his prescription, just as he pays for most of his medications.

Amount of co-pay varies by health plan.

G

generic drugs

A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates generic drugs to be as safe and effective as brand-name drugs.

Gold Health Plan

Plans in the Healthplanfinder marketplace are available in 4 health plan categories — Bronze, Silver, **Gold**, and Platinum — based on the percentage that each plan pays of the average overall cost of providing essential health benefits to members. *The plan category you choose affects the total amount you'll likely spend for essential health benefits during the year.* The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), **80% (Gold)**, and 90% (Platinum). This is not the same as co-insurance, in which you pay a specific percentage of the cost of a specific service.

guaranteed issue

A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Guaranteed issue does not limit how much you can be charged if you enroll.

guaranteed renewal

A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. Guaranteed renewal does not limit how much you can be charged if you renew your coverage.

habilitative/habilitation services

Health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include:

- Physical and occupational therapy
- Speech-language pathology
- Other services for people with disabilities in a variety of inpatient and/or outpatient settings

hardship exemption

Under the Affordable Care Act, most people must pay a fee if they don't have health coverage that qualifies as "minimum essential coverage." One exception is based on showing that a "hardship" prevented them from becoming insured.

Health Care Authority (HCA)

The Washington State Health Care Authority is a government agency that oversees the state's two top health care purchasers: Washington **Apple Health** (Medicaid) and the Public Employees Benefits Board (PEBB) Program, as well as other programs. For more information visit: hca.wa.gov or call 1-800-562-3022 for questions about Washington **Apple Health**.

Healthplanfinder

The Washington Health Benefit Exchange was created in state statute in 2011 as a "public-private partnership," separate and distinct from the state. The Exchange is responsible for the creation of *Washington Healthplanfinder*, an online marketplace for individuals, families, and small businesses to find, compare, and enroll in Qualified Health Plans as well as enroll in Apple Health. *Washington Healthplanfinder* offers Washington State residents:

- Side-by-side comparisons of Qualified Health Plans (QHPs)
- Tax credits or financial help to pay for co-pays and premiums
- Customer support online, *by phone or in-person* through a local organization or insurance broker

For more information, visit wahealthplanfinder.org or call: 1-855-923-4633.

See also **health insurance marketplace**.

health insurance

A contract between an individual and a health insurance plan or provider that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

health insurance marketplace (Healthplanfinder)

A resource where individuals, families, and small businesses can:

- Learn about their health insurance plan options
- Compare plans based on costs, benefits, and other important features
- Choose a plan
- Enroll in coverage

The Healthplanfinder marketplace also provides information on programs that help people with low-to-moderate incomes and resources pay for coverage. This includes ways to save on monthly premiums and out-of-pocket costs for coverage, and information about other programs, including Medicaid (Apple Health).

In Washington State, the Health Insurance Marketplace is Healthplanfinder.

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 will not cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area in order to be eligible for health insurance coverage. HMOs often provide integrated care and focus on prevention and wellness.

health plan categories

Plans in the Healthplanfinder marketplace are available in 4 health plan categories — **Bronze**, **Silver**, **Gold**, or **Platinum** — based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. *The plan category you choose affects the total amount you'll likely spend for essential health benefits during the year.* The percentages the plans will spend, on average, are **60% (Bronze)**, **70% (Silver)**, **80% (Gold)**, and **90% (Platinum)**. This is not the same as co-insurance, in which you pay a specific percentage of the cost of a specific service.

Health Reimbursement Account (HRA)

Health Reimbursement Accounts (HRAs) are employer-funded group health plans that reimburse employees tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements.

Health Savings Account

A type of medical savings account that allows consumers to save for medical expenses on a tax-free basis. To qualify, applicants must enroll in a **high deductible health plan**. A high deductible plan usually means higher out-of-pocket expenses, but a lower premium. The funds contributed to the account are not subject to federal income tax at the time of deposit.

Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over from year to year if you don't spend them.

High Deductible Health Plan (HDHP)

A plan that features higher deductibles than traditional insurance plans. You can combine a high deductible health plan (HDHP)) with a health savings account or a health reimbursement account to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

HIPAA eligible individual

This is your status once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, at least the last day of your creditable coverage must have been under a employer health plan. You also must:

- Have used up any COBRA or state continuation coverage
- Not be eligible for Medicare or Medicaid
- Not have other health insurance
- Apply for individual health insurance within 63 days of losing your prior creditable coverage

When you're buying individual health insurance, HIPAA eligibility gives you greater protections than you would otherwise have under state law.

home health care

Health care services that a person receives at home.

Home and Community-Based Services (HCBS)

Services and support provided by most state Medicaid programs in your home or community that help with such daily tasks as bathing or dressing. This care is covered when provided by care workers or, if your state permits, by your family.

hospice services

Services to provide comfort and support for persons in the last stages of a terminal illness, and for their families.

hospital readmission

A situation where you were discharged from the hospital and then go back in for the same or related care within 30, 60 or 90 days. The number of hospital readmissions is often used in part to measure the quality of hospital care, since it can mean that your follow-up care was not properly organized, or that you were not fully treated before discharge.

hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

hospital outpatient care

Care in a hospital that usually does not require an overnight stay.

In-Person Assistance (IPA) Personnel Program

Individual or organizations that are trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Healthplanfinder marketplace. These individuals and organizations can help consumers complete eligibility and enrollment forms. They are required to be unbiased, *and their services are **free** to consumers.*

in-network co-insurance

The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

in-network co-payment

A fixed amount (for example, $15) you pay at each visit for covered health care services, from providers who contract with your health plan. Most plans will cover some cost from out-of-network providers. This coverage will be at a lower level than in-network.

HOW IT WORKS

Laura needs to see a counselor. She found one near her home. She calls the counselor's office and asks if the counselor is in her health plan's network before scheduling a visit. Health plans typically won't pay for care at places that are outside their network group.

ASK IF YOUR PROVIDER IS IN-NETWORK BEFORE SCHEDULING A VISIT

individual health insurance policy

Policies for people who are not connected to job-based coverage. Individual health insurance policies are regulated under state law.

inpatient care

Health care that you get when you are admitted as an inpatient to a health care facility, such as a hospital or skilled nursing facility.

insurance co-op

A nonprofit entity in which the same people who own the company are insured by the company. Insurance cooperatives (co-ops) can be formed at a national, state, or local level. They can include doctors, hospitals, and businesses as member-owners.

L

lawful permanent resident or legal permanent resident (LPR)

This is the status given to lawful residents with intent to reside. Legal permanent residents must meet 5-year requirements to be Medicaid eligible even if they are income eligible. LPRs are eligible for tax credits if they file taxes and can apply for Qualified Health Plans (QHPs).

lifetime limit

A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (for example, a $1 million lifetime cap) or limits on specific benefits (for example, a $200,000 lifetime cap on organ transplants or one gastric bypass per lifetime), or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

long-term care

Services that include medical and non-medical care for people who are unable to perform basic activities of daily living, such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living centers, or in nursing homes. Individuals may need long-term supports and services at any age.

Medicare and most health insurance plans *do not* pay for long-term care.

M

marketplace

See **health insurance marketplace**.

Medicaid

A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities. In some states, low-income adults are also eligible. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies by state and may have different names. In Washington State, the Medicaid program is called **Apple Health**.

medical loss ratio (MLR)

A basic financial measurement used in the Affordable Care Act (ACA) to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, agent commissions and state taxes and fees. The Affordable Care Act requires insurance plans to spend at least 80% or 85% of consumer premium dollars on medical care. If they fail to meet these standards, the health insurance plans must provide a rebate to their customers

medically necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare

A federal health insurance program for people aged 65 or older and certain younger people with disabilities. Medicare also covers people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). Individuals apply for Medicare through the Social Security Administration and NOT through *Washington Healthplanfinder*. For more information, visit ssa.gov/medicare.

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 of your Medicare 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, Medicare services are covered through the plan and are not 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: 1) through a Medicare Prescription Drug Plan or 2) through a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

minimum essential coverage

The type of coverage an individual must have to meet the individual responsibility requirement under the Affordable Care Act (ACA). This includes individual market policies, job-based coverage, Medicare, Medicaid (Apple Health), CHIP (Children's Apple Health), TRICARE, and certain other coverage.

minimum value

A health plan meets this standard if it is designed to pay at least 60% of the total cost of medical services for a standard population. Starting in 2014, individuals offered employer-sponsored coverage that provides minimum value and that is considered affordable will not be eligible for a premium tax credit.

modified adjusted gross income (MAGI)

The figure used to determine eligibility for lower costs in the Healthplanfinder marketplace and for Medicaid (Apple Health) and CHIP (Children's Apple Health). Generally, this MAGI figure is your adjusted gross income plus any tax-exempt Social Security, interest, or foreign income you have.

navigator (in-person assister)

An individual or organization that's trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Healthplanfinder marketplace. They can help you complete eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

See also **In-Person Assistance (IPA) Personnel Program**.

network

The facilities, providers, and suppliers with whom your health insurer or plan has contracted to provide health care services.

network plan

A health plan that contracts with doctors, hospitals, pharmacies, and other health care providers to provide plan members with services and supplies at a discounted price.

non-discrimination

A requirement that job-based coverage not discriminate based on health status. Coverage under job-based plans cannot be denied or restricted. You also cannot be charged more because of your health status. Job-based plans can restrict coverage based on other factors, such as part-time employment, that are not related to health status.

Open Enrollment Period

The period of time each year when eligible individuals can enroll in a Qualified Health Plan in the Healthplanfinder marketplace. For coverage starting in 2015, the Open Enrollment Period is November 15, 2014–February 15, 2015. Individuals may also qualify for special enrollment periods outside of Open Enrollment if they experience certain events. (See special enrollment period and qualifying life event.)

You can apply for Medicaid or CHIP (Apple Health) at any time of the year.

out-of-network co-insurance

The percentage (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

out-of-network copayment

A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually cost you more than in-network co-payments.

out-of-pocket costs

Your expenses for medical care that are not reimbursed or covered by insurance. Out-of-pocket costs include deductibles, co-insurance, and co-payments for covered services, plus all costs for services that are not covered.

out-of-pocket estimate

An estimate of the amount that you may have to pay on your own for health care or prescription drug costs. The estimate is made before your health plan has processed a claim for that service.

out-of-pocket maximum/limit

The maximum amount you will pay in 1 *calendar year* for health services, NOT including premium payments or out-of-network costs. This limit must include deductibles, co-insurance, co-payments, or similar charges. It must include any other expenditure required of an individual that is a qualified medical expense for the essential health benefits.

HOW IT WORKS

Shirley has two children with asthma. One of her children has a severe asthma attack and is hospitalized. Shirley's emergency room and hospital bills total $8,000. Shirley first pays her deductible which is $2000 which leaves a balance of $6000. Then she pays 20% co-insurance which is $1200. The remaining portion of the bill is $4800 and is paid by her health plan.

Shirley's health insurance plan has an out-of-pocket maximum of $4,000. This year she has paid $3200 in health care costs. She will need to pay $800 more before her health plan begins to pay all of her costs later in the year.

Numbers are estimates, call your specific health plan for more details.

1. $8,000 (TOTAL BILL) − $2,000 (DEDUCTIBLE PAID BY SHIRLEY) = $6,000 (REMAINING BALANCE)
2. $6,000 (REMAINING BALANCE) × 20% (CO-INSURANCE) = $1200 (ADDITIONAL AMOUNT PAID BY SHIRLEY)
3. $8,000 (TOTAL BILL) − $3,200 (TOTAL AMOUNT PAID BY SHIRLEY) = $4,800 (PAID BY HEALTH PLAN)

➡ $4,000 (OUT-OF-POCKET MAXIMUM) − $3,200 (AMOUNT SHIRLEY HAS PAID SO FAR THIS YEAR) = $800 (AMOUNT REMAINING UNTIL HEALTH PLAN PAYS 100%)

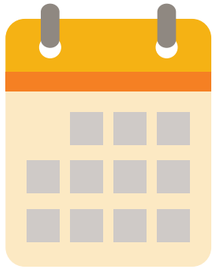
The maximum out-of-pocket cost limit for any individual Healthplanfinder plan for 2014 cannot exceed $6,350 for an individual plan and $12,700 for a family plan.

payment bundling

A payment structure in which different health care providers who are treating you for the same or related conditions are paid an overall sum for taking care of your condition rather than being paid for each treatment, test, or procedure. This rewards providers for coordinating care, preventing complications and errors, and reducing unneeded or duplicative tests and treatments.

plan

Plans in the Healthplanfinder marketplace are available in 4 health plan categories — **Bronze**, **Silver**, **Gold**, or **Platinum** — based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. *The plan category you choose affects the total amount you'll likely spend for essential health benefits during the year.* The percentages the plans will spend, on average, are **60% (Bronze)**, **70% (Silver)**, **80% (Gold)**, and **90% (Platinum)**. This is not the same as co-insurance, in which you pay a specific percentage of the cost of a specific service.



plan year

A 12-month period of benefits coverage under a employer health plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies, this 12-month period is called a **policy year**.)

Platinum Health Plan

Plans in the Healthplanfinder marketplace are available in 4 health plan categories — Bronze, Silver, Gold, or **Platinum** — based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. *The plan category you choose affects the total amount you'll likely spend for essential health benefits during the year.* The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and **90% (Platinum)**. This is not the same as co-insurance, in which you pay a specific percentage of the cost of a specific service.

Point of Service (POS) Plans

In these plans, 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.

policy year

A 12-month period of benefits coverage under an individual health insurance plan. This 12-month period may not be the same as the calendar year. To find out when your policy year begins, you can check your policy documents or contact your insurer. (Note: In employer health plans, this 12-month period is called a **plan year**.)

pre-existing condition

A health problem or illness you had before the date that new health coverage starts.

preauthorization

A decision by your health insurance plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization is not a promise that your health insurance plan will cover the cost.

preferred provider

An in-network provider who has a contract with your health insurance plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers. Some health insurance or plans have "tiered" networks, and you must pay extra to see some providers. Your health insurance plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer plan, but the discount may not be as great, and you may have to pay more.

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.

pregnancy medical (program)

Pregnant women are eligible for this program if they meet certain income guidelines. Undocumented pregnant women qualify regardless of income. Coverage lasts until after the birth of the child.

premium

The cost of your health insurance plan per month. You must pay this amount even when you do not get any medical care.

Health plan premiums are due on the 23rd of each month by 4:59 p.m.

HOW IT WORKS

Just like her electricity or phone bill, Jean pays her health plan premium each month. Premiums are due on the 23rd of the month by 4:59 p.m. Jean mails her payment a few days early or pays online to make sure that her health plan stays active.

ALLOW TIME FOR PAYMENTS TO POST BY MAILING EARLY

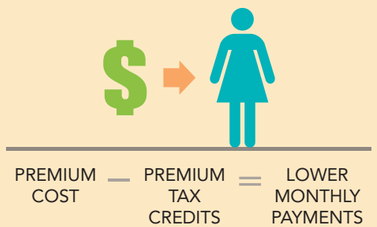
Premium Subsidies (Premium Tax Credits or Health Insurance Premium Tax Credit – HIPTC)

Tax credits that ***reduce* premium** costs. Credits can be given at the time of purchase. This help is also known as a premium tax credit.

HOW IT WORKS

Marcela is an uninsured single adult. She makes $25,000 a year (about $2,000 a month). Marcela's earnings make it possible for her to get financial help called premium subsidies. This financial help reduces the cost of Marcela's premium payments.

Contact *Washington Healthplanfinder* for actual numbers.



The Affordable Care Act provides a new tax credit to help you afford health coverage purchased through the Healthplanfinder marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose the amount of advance credit payments to apply to your premiums each month, up to a maximum amount.

If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return.

If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your federal income tax return.

To find out if you are eligible for premium subsidies, visit wahealthplanfinder.org or call 1-855-WAFINDER (1-855-923-4633).

prevention

Activities to prevent illness, such as routine check-ups, immunizations, patient counseling, and screenings.

preventive services

Health care services, such as yearly health exams and flu shots, that are paid for by your health insurance plan at little or no cost to you. These services are covered only when they are provided by an in-network provider.

HOW IT WORKS

Taylor wants to stay healthy, so she gets a health exam and a flu shot each year. She likes that her health plan pays for services that keep her from getting sick.

primary applicant

An individual who creates an account on *Washington Healthplanfinder* and initiates one of three application types: 1) for individuals: myself; 2) for household members: myself and others; or 3) for the household: other household members.

primary care

Health services that cover a range of prevention, wellness, and treatment services for common illnesses.

primary care provider (PCP)

The main doctor or nurse whom you choose to visit as part of your health plan. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with you, give advice, and treat you on a range of health-related issues. They may also coordinate your care with specialists.

HOW IT WORKS

Roger has a health insurance plan for the very first time. In the past, he went to the ER if he was feeling sick. Now he can choose a primary care provider (PCP). His PCP is his main doctor.

prior authorization

Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan. It is important to ask if prior authorization is required before you have a service or fill a prescription. See also **preauthorization**.

Q

Qualified Health Plan (QHP)

Under the Affordable Care Act, starting in 2014, a Qualified Health Plan is an insurance plan that is certified by the Washington State Healthplanfinder marketplace. It must provide essential health benefits, follows established limits on cost-sharing (such as deductibles, co-payments, and out-of-pocket maximum amounts), and meet other requirements. A Qualified Health Plan will have a certification by each marketplace in which it is sold.

qualifying life event

A change in your life that can make you eligible for a **special enrollment period** to enroll in health coverage. Examples of qualifying life events are: moving to a new state; certain changes in your income; and changes in your family size (for example, if you marry, divorce, or have a baby).

R

referral

A written order from your primary care provider (PCP) for you to see a specialist or get certain medical services. If you do not get a referral first, your health insurance plan may not pay for the services.

rehabilitative/rehabilitation services

Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

S

secondary insurance

A secondary insurance payer that only pays if there are costs the primary insurer did not cover. The secondary insurance payer may not pay all of the uncovered costs. Medicare is a common secondary payer for eligible individuals in some situations.

service area

A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. You may lose coverage if you move out of the plan's service area.

Silver Health Plan

Plans in the Healthplanfinder marketplace are available in 4 health plan categories — Bronze, **Silver**, Gold, or Platinum — based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. *The plan category you choose affects the total amount you'll likely spend for essential health benefits during the year.* The percentages the plans will spend, on average, are 60% (Bronze), **70% (Silver)**, 80% (Gold), and 90% (Platinum). This is not the same as co-insurance, in which you pay a specific percentage of the cost of a specific service.

skilled nursing care

Services from licensed nurses in your own home or a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

special enrollment period

A time outside of the Open Enrollment Period when you and your family have a right to sign up for health coverage. In Healthplanfinder (Washington's insurance marketplace), you qualify for a special enrollment period 60 days following certain life events that involve a change in family status (for example, marriage or the birth of a child) or loss of other health coverage. Job-based plans must provide a special enrollment period of 30 days.

special health care needs

The health care and related needs of children who have chronic physical, developmental, behavioral, or emotional conditions. These needs exceed the type or amount generally required by children.

specialist

A **physician specialist** is a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A **non-physician specialist** is a provider, but not a doctor, who has additional training in a specific area of health care.

subsidized coverage

Health coverage that can be obtained through financial assistance programs to help people with low- and middle-incomes.

Summary of Benefits and Coverage (SBC)

An easy-to-read summary that lets you compare the costs and coverage of health plans. You can compare plans based on price, benefits, and other features that may be important to you. You will get a Summary of Benefits and Coverage (SBC) when you shop for coverage on your own or through your job, and when you renew or change coverage. You may also request an SBC from the health insurance company.

T

tax household

The taxpayer(s) and any individuals who are claimed as dependents on one federal income tax return. A tax household may include a spouse and/or dependents.

total cost estimate (for health coverage)

The total amount you may have to pay for health plan coverage, estimated before you actually have the coverage.

U

UCR (usual, customary, and reasonable)

The amount paid for a medical service in a geographic area, based on what providers in the area usually charge for the same or similar medical service. The UCR amount is sometimes used to determine the allowed amount.

urgent care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not severe enough to require emergency room care.

V

vision or vision coverage

Vision coverage is a health benefit that at least partially covers vision care such as eye exams and glasses. All Qualified Health Plans (QHPs) sold on Healthplanfinder include pediatric vision coverage. QHPs do not have to include adult vision coverage.

If adult vision coverage is important to you, check the details of any plan you're considering to see if it is included.

If your Qualified Health Plan does not include adult vision coverage, you can buy a "stand-alone" vision plan. Stand-alone vision plans aren't offered through the Healthplanfinder marketplace, and tax credits cannot be applied to them. Learn about available stand-alone vision plans by contacting your Washington State's Department of Insurance, or a local agent or broker.

W

Washington Healthplanfinder

Washington Healthplanfinder is an online marketplace for individuals, families and small businesses to find, compare and enroll in Qualified Health Plans as well as enroll in Apple Health. *Washington Healthplanfinder* offers Washington State residents:

- Side-by-side comparisons of Qualified Health Plans
- Tax credits or financial help to pay for co-pays and premiums
- Customer support online, by phone or in-person through a local organization or insurance broker

For more information, visit wahealthplanfinder.org or call 1-855-923-4633.

See also **health insurance marketplace**.

well-baby and well-child visits

Routine doctor visits for comprehensive preventive health services when a baby is young and annual visits until a child reaches age 21. Services include physical exams and measurements, vision and hearing screening, and oral health risk assessments.

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