Insurance Glossary

Essential Terms for ACA Health Insurance, Supplement Insurance & More

About This Glossary

This comprehensive glossary provides clear, consumer-friendly definitions of key insurance terms. Whether you're exploring ACA marketplace plans, considering supplement insurance, or simply trying to understand your coverage options, this resource will help you navigate the complex world of health insurance with confidence.

Terms & Definitions

A

ACA (Affordable Care Act)

Also known as "Obamacare," this federal law enacted in 2010 reformed the healthcare system by expanding access to affordable health insurance, establishing health insurance marketplaces, and requiring most Americans to have health coverage or pay a penalty.

Actuarial Value

The percentage of total average costs for covered benefits that a health 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.

Annual Limit

A cap on the benefits your insurance company will pay in one year while you're enrolled in a particular health insurance plan. After the 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. You may appeal if your health plan denies payment for a service or treatment you believe should be covered.

B

Bronze Plan

A health insurance plan category that provides the lowest monthly premiums but the highest costs when you need care. Bronze plans pay about 60% of health care costs on average, while you pay about 40%.

Balance Billing

When a provider bills you for 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.

Beneficiary

The person who benefits from an insurance policy. This includes the subscriber (primary insured) and any covered dependents.

C

COBRA

The Consolidated Omnibus Budget Reconciliation Act allows you to temporarily continue health coverage after your employment ends, you lose coverage as a dependent, or another qualifying event occurs. You usually pay the full premium yourself, plus a small administrative fee.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (like 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe.

Copayment (Copay)

A fixed amount (like $20) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Coverage Gap

Also called the "donut hole." In Medicare Part D, it's a temporary limit on what the drug plan will cover for drugs. Not all plans have a coverage gap.

D

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.

Dependent

A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the ACA, you can add dependent children up to age 26 to your health insurance policy.

Durable Medical Equipment (DME)

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

E

Emergency Services

Care in a hospital emergency room, or care you get for a condition that could seriously jeopardize your health if you don't get immediate medical attention.

Essential Health Benefits

A set of health care service categories that must be covered by certain plans, starting in 2014. These include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services, laboratory services, preventive care, and pediatric services.

Explanation of Benefits (EOB)

A statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf.

F

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.

FSA (Flexible Spending Account)

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.

G

Gold Plan

A health insurance plan category that provides moderate monthly premiums and moderate costs when you need care. Gold plans pay about 80% of health care costs on average, while you pay about 20%.

Grace Period

Additional time allowed to make premium payments without losing health coverage. Marketplace plans and other individual health insurance plans must provide at least a 30-day grace period.

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.

H

Health Insurance 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.

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. HSAs are only available with High-Deductible Health Plans (HDHPs).

HMO (Health Maintenance Organization)

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.

Hospice Care

Services to provide comfort and support to persons in the last stages of a terminal illness and their families. Hospice care emphasizes pain management and emotional support rather than curative treatment.

I

In-Network

Providers or health care facilities which are part of a health plan's network of providers with which it has negotiated a discount. Typically, you pay less when using an in-network provider.

Individual Mandate

The requirement under the ACA that most Americans have health insurance or pay a penalty. The federal penalty was reduced to $0 starting in 2019, but some states have their own individual mandates.

L

Lifetime Limit

A cap on the total lifetime benefits you may get from your insurance company. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. The ACA prohibits lifetime limits on essential health benefits.

Long-Term Care

Services to support your personal care needs. Most long-term care is not medical care, but rather assistance with basic personal tasks of everyday life, sometimes called Activities of Daily Living (ADLs).

M

Medicaid

A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state.

Medicare

Federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

Medicare Supplement Insurance (Medigap)

Insurance sold by private companies that can help pay some of the health care costs that Original Medicare doesn't cover, like copayments, coinsurance, and deductibles.

Metal Tiers

Categories of health insurance plans (Bronze, Silver, Gold, Platinum) based on how you and the plan share costs. Bronze plans have the lowest monthly premiums but highest costs when you need care.

N - O

Network

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

Open Enrollment Period

The yearly period when people can enroll in a health insurance plan. Open Enrollment for most individual health insurance plans runs from November 1 to December 15 for coverage starting January 1.

Out-of-Network

Providers or health care facilities which are not part of a health plan's network of providers. You'll typically pay more to use an out-of-network provider.

Out-of-Pocket Costs

Health care costs 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 have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

P

Platinum Plan

A health insurance plan category that provides the highest monthly premiums but the lowest costs when you need care. Platinum plans pay about 90% of health care costs on average, while you pay about 10%.

PPO (Preferred Provider Organization)

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.

Pre-authorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization or prior approval.

Pre-existing Condition

A health problem you had before the date that new health coverage starts. Under the ACA, health insurance companies cannot refuse coverage or charge more because of pre-existing conditions.

Premium

The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.

Premium Tax Credit

A refundable tax credit designed to help eligible individuals and families with low or moderate income afford health insurance purchased through the Health Insurance Marketplace.

Preventive Care

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Under the ACA, most preventive care is covered at 100% with no cost-sharing.

Primary Care Provider (PCP)

A health care provider who gives you basic medical care. PCPs are usually doctors, but nurse practitioners and physician assistants can sometimes be PCPs. In some plans, you need a referral from your PCP to see other providers.

Q - R

Qualifying Life Event

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples include losing health coverage, moving, getting married, having a baby, or adopting a child.

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 a referral before you can get medical care from anyone other than your primary care doctor.

Rider

Additional insurance coverage that can be added to a basic insurance policy for an extra premium. Riders provide benefits for specific conditions or situations not covered under the standard policy.

S

Silver Plan

A health insurance plan category that provides moderate monthly premiums and moderate costs when you need care. Silver plans pay about 70% of health care costs on average, while you pay about 30%.

Special Enrollment Period

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, like losing health coverage, moving, getting married, having a baby, or adopting a child.

Specialist

A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

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.

Supplement Insurance

Additional insurance coverage that helps pay health care costs not covered by your primary health insurance. This includes Medicare Supplement Insurance (Medigap) and other supplemental health policies.

T - U

Telehealth

The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, and public health administration.

Underwriting

The process by which insurance companies evaluate your application and decide whether to offer you coverage, at what premium, and with what exclusions or conditions. The ACA limits underwriting for individual health insurance.

Urgent Care

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

W

Waiting Period

The time that must pass before coverage can become effective for you or your dependents who are otherwise eligible for coverage under a group health plan.

Waiver

Permission to exclude or modify a standard insurance policy provision. For example, some states have received waivers to modify certain ACA requirements.

Need More Help?

This glossary covers essential insurance terms, but every situation is unique. For personalized guidance on choosing the right health insurance plan or understanding your coverage options, consider consulting with a licensed insurance professional or visiting HealthCare.gov for official information about ACA marketplace plans.

Understanding your insurance options is the first step toward making informed healthcare decisions.