

Glossary of Health Insurance Terms

Benefit Year: A year of benefits coverage under an individual health insurance plan. The benefit year for plans bought inside or outside the Marketplace begins January 1 of each year and ends December 31 of the same year. Your coverage ends December 31 even if your coverage started after January 1.

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

Coinsurance: The percentage (for example, 20%) you pay of the allowed amount for covered health care services to providers.

Copayment: A fixed amount you pay your health care provider for service covered by your insurance.

Cost-Sharing Reduction: Assistance offered along with the Premium Tax Credit, which is used to reduce the out of pocket costs to the consumer, such as the deductible, co-pay amount, or co-insurance percentage. Consumers enrolling through MHC must enroll into the “silver” level plan to access the cost-sharing benefit.

Deductible: An amount a participant pays, per benefit year, before insurance benefits begin.

Essential Health Benefits: Ten categories of services that must be covered by most insurance plans as mandated by the Affordable Care Act.

Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. This may be broken down in tiers, which determine how much a consumer will pay for a specific drug under that plan.

Maryland Health Connection: Maryland’s official health insurance marketplace through which residents can compare qualified health plans, enroll in health insurance, and determine eligibility for federal tax credits, cost-sharing reductions, and assistance programs.

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

Out-of-Pocket Maximum: The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. Out-of-pocket limits include deductibles, coinsurance, copayments, or similar charges. This limit does not include premiums, balance billing amounts for non-network providers and other out-of-network cost sharing, or spending for non-essential health benefits.

Pre-Existing Condition: A health problem you have before your health insurance coverage starts.

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

Preventive Care: Care required to help a participant stay healthy, avoid disease, or keep chronic health conditions in check.

Primary Care Provider: A doctor, nurse practitioner, or anyone else allowed by law to coordinate your care with other health care providers.

Qualified Health Plan: 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.

Qualifying Life Event: A change in your life (such as moving to a new state, getting married or divorced, or having a baby) that makes you eligible to enroll in health coverage within a specific period of time after that event occurs.

Referral: A written order from your doctor to see a specialist or to get special services. Many HMOs require a referral to get medical services from anyone other than your primary care provider. If you don’t get a referral first, your insurance plan may not pay for the services.

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