# 20 health insurance terms to know before you enroll

## 1. Affordable Care Act

Often referred to as the ACA, PPACA, or Obamacare – the Affordable Care Act is comprehensive health care reform signed into law in March 2010. One of the primary goals of the ACA is to make health insurance more affordable and accessible, providing consumers with tax credits that can overall lower the cost of their health insurance — depending on their household size and income.

## 2. Marketplace

The “Health Insurance Marketplace” (sometimes referred to as the “exchange”) is the one-stop shopping and enrollment service created by the ACA. For many states, the federal government runs the Marketplace via HealthCare.gov. However, some states run their own Marketplace on different websites.

## 3. Open Enrollment Period

This is the annual period when people are able to compare, shop for, and enroll in health insurance plans. Last year, the Open Enrollment Period ran between November 1st and December 15th.

## 4. Special Enrollment Period

If something prevents you from enrolling during the annual Open Enrollment Period, you still might be able to sign up for health insurance during a Special Enrollment Period. Specifically, if you experience an approved qualifying life event (QLE):

- Losing your health coverage
- Moving
- Marriage
- Having or adopting a child

- Plus more

And you typically have 60 days to enroll following your QLE.

## 5. Premium

A premium is your monthly health insurance payment. However, premiums do not cover the full cost of healthcare. Often there are additional costs including your deductible and copayments. An important note: plans with higher premiums have lower deductibles, and could save you money in the long run.

## 6. Coinsurance

This is the amount your insurance will pay for a covered service, only after you've met your deductible. For example, say your health insurance plan allows $100 per office visit with a 20% coinsurance rate. If your deductible has been met, you pay $20. If you haven't met your deductible, you pay the full amount of $100.

## 7. Out-of-pocket max

An out-of-pocket maximum is the most you will have to pay for a covered service within a year. Once the required amount has been spent on deductibles, copayments, and coinsurance, your health insurance plan will cover the remainder of covered benefits.

This does not include premiums or services that are not covered by your plan. And your benefits summary will provide information regarding what is and isn't covered.

## 8. Deductible

Your deductible is the amount you pay for a covered health care service before your health insurance plan kicks in. For example, if you have a $2,000 deductible, you will pay the first $2,000 worth of covered services by yourself. And then your insurance company will step in to pay the remainder.

## 9. Copayment

A copayment is a fixed amount that you will pay for a covered health care service, after you've paid your deductible. For example, let's say seeing your primary care doctor is $150 per visit. Your health insurance plan guarantees a $40 copay. If you've met your deductible, then you will only pay $40 for your visit.

## 10. Essential health benefits

Essential health benefits are the services covered by every health insurance plan offered through the Marketplace. That means, whatever plan you choose will include the following:

- Ambulatory services
- Pregnancy and childbirth
- Pediatric services
- Preventive services
- Prescription drugs
- Hospitalization
- Mental health and substance use disorder services
- Emergency services
- Rehabilitative services
- Lab services

## 11. Subsidy (cost-sharing reduction/ advance premium tax credit)

Each of these terms refers to coverage at a reduced cost.

A cost-sharing reduction is a discount that lowers the amount you have to pay in deductibles, copayments, and coinsurance. An advance premium tax credit is a tax credit taken in advance to lower your monthly health insurance premium.

All subsidized coverage depends on your household size and income.

## 12. Metal levels (bronze, silver, gold, platinum)

Metal levels represent the different kinds of plans in the Marketplace. These names have nothing to do with the quality of care received, they simply differentiate how costs are divided between you and your insurance plan.

## 13. Network types (HMO, PPO, etc.)

The most common plans you'll encounter in the Marketplace are HMO, PPO, EPO, and POS.

- Health Maintenance Organization (HMO): A type of plan that gives you access to providers, hospitals, and specialists within its network. It usually does not cover out-of-network care and focuses primarily on preventive care.

- Preferred Provider Organization (PPO): A type of plan where there is more flexibility in choosing a doctor specialist, or hospital.

- Point of Service (POS): A type of plan where you pay less if you use services and providers in-network.

- Exclusive Provider Organization (EPO): A type of plan where only in-network services and providers are covered (except for in an emergency).

## 14. Dependent

A dependent is someone who you can claim a personal exemption tax deduction, such as a child. Under the ACA, individuals can claim a premium tax credit to help cover their dependents.

## 15. Effectuation date

Once you make your first payment, this is the date when your Marketplace health insurance policy becomes active.

## 16. In-network

In-network doctors, hospitals, and other providers accept your health insurance plan and have agreed with insurance companies to a pre-approved cost for services.

## 17. Out-of-network

Out-of-network doctors, hospitals, and other providers do not accept the pre-approved cost mentioned above. Individuals are responsible for paying the difference between their plan's approved amount and what the provider charges.

## 18. Pre-existing condition

A pre-existing condition is a health issue you had before your health coverage began. Common examples include asthma and diabetes. Marketplace insurance plans cannot deny treatment or charge a higher premium based on a pre-existing condition.

## 19. Preventive services

Preventive services are routine health care services such as annual check-ups and women's wellness exams — and they are free in every Marketplace plan. Their goal is to prevent illness and other health problems that could be more serious and expensive over time.

## 20. Drug formulary

A drug formulary, also called a drug list, are the prescription drugs covered by a specific insurance plan.