Your 2019 ACA Guide to Medical Terms

Allowed Amount

The maximum amount a plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

If your provider charges more than the plan's allowed amount, you may have to pay the difference. (See Balance Billing)

Actuarial Value

The percentage of total average costs for covered benefits that a 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. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

Affordable Care Act (ACA)

The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or "Obamacare").

The law has 3 primary goals:

- Make affordable health insurance available to more people. The law provides consumers with subsidies ("premium tax credits") that lower costs for households with incomes between 100% and 400% of the federal poverty level.
- Expand the Medicaid program to cover all adults with income below 138% of the federal poverty level. (Not all states have expanded their Medicaid programs.)
- Support innovative medical care delivery methods designed to lower the costs of health care generally.

Attest/Attestation

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

Affordable coverage

A job-based health plan covering only the employee that costs 9.56% or less of the employee's household income. If a job-based plan is "affordable," and meets the "minimum value" standard, you're not eligible for a premium tax credit if you buy a Marketplace insurance plan instead.

- The plan used to define affordability is the lowest priced "self-only" plan the employer offers — meaning a plan covering **only** the employee, not dependents. This is true even if you're enrolled in a plan that costs more or covers dependents.
- The cost is **the amount the employee would pay** for the insurance, not the plan's total premium.

- The employee's **total household income** is used. Total household income includes income from everybody in the household who's required to file a tax return.

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. A **preferred provider** may not balance bill you for covered services.

Co-insurance

The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Co-payment

A **payment** made by an individual who has health insurance, usually at the time a service is received, to offset some of the cost of care. **Co-payments** are a common feature of HMO (Health Maintenance Organization) and PPO (Preferred Provider Organization) health plans in the US.

Deductible

The amount you pay for covered health care services before your insurance plan starts to pay.

Durable Medical Equipment(DME)

is defined as tools which are used in the patient's home and are designed to help improve the quality of life for someone with a **medical** condition. A back brace or a wheelchair is an example of **durable medical equipment**.

Eligible Employee

an **Eligible** Employee is a full-time regular hire employee of the Company or any **Employer**, who is notified by the Company in writing that he or she is **eligible** for participation in the Plan.

Evidence of Coverage (EOC)

The term **evidence** of **coverage** in the context of health insurance refers to any certificate or individual or group agreement or contract issued in concurrence with the certificate, agreement or contract issued to a subscriber. It contains information regarding **coverage** and other rights to which an enrollee is entitled.

Open Enrollment

The time of year for **open enrollment** depends on the **health care** plan you choose: Medicare **open enrollment** runs from October 15 to December 7 each year. Job-based **health insurance open enrollment** periods are set by your employer and can happen at any time of the year.

Out of Pocket Maximum
An out-of-**pocket maximum** is a predetermined, limited amount of money that an individual must pay before an insurance company or (self-insured employer) will pay 100 percent for an individual's health care expenses.

Preauthorization
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, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.

Prior Deductible Credit
Prior carrier **deductible credit** applies if the current PPO policy is replacing a similar policy that had previously been issued to the group policyholder. ˜ is means that insureds electing a PPO plan must be replacing a PPO plan with their **prior** carrier.

Qualifying Life Event(QLE)
A change in your situation — like getting married, having a baby, or losing health coverage — that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the yearly Open Enrollment Period.

Summary of Benefits and Coverage(SBC)
is a **document that all insurance companies are required to provide consumers** as a result of health care reform. It is a standardized summary of health plan benefits and coverage, including **covered benefits, cost sharing examples, and coverage limitations and exceptions**.

Prescription Drug Terms Index

Generic
A generic drug is a pharmaceutical drug that is equivalent to a brand-name product in dosage, strength, route of administration, quality, performance, and intended use.

In most cases, generic products become available after the patent protections afforded to a drug's original developer expire.

Brand
Brand drug that has a trade name and is protected by a patent (can be produced and sold only by the company holding the patent).

Formulary List

A drug formulary is a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value.

A committee of physicians, nurse practitioners, and pharmacists maintain the formulary.

Non-Formulary Drugs

Non-formulary prescriptions aren't on the insurance policy's list of preferred drugs. Non-formularies are more costly.

Specialty Drugs

Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis.

Specialty drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion).

Retail Pharmacy

A pharmacy in which drugs are sold to patients, as opposed to a hospital pharmacy.

Mail Order

An online pharmacy, Internet pharmacy, or mail-order pharmacy is a pharmacy that operates over the Internet and sends the orders to customers through the mail or shipping companies.

Tier 1, 2, 3, 4 Drugs

Tiers 1, 2, 3, and 4 drugs listed on the summary of benefits. Drugs on a formulary are typically grouped into tiers.

The tier that your medication is in determines your portion of the drug cost. A typical drug benefit includes three or four tiers:

- **Tier 1** usually includes generic medications.
- **Tier 2** usually includes preferred brand name medications.
- **Tier 3** usually includes non-preferred brand name medications.
- **Tier 4** usually includes specialty medications (3-Tier programs do not have a unique tier for specialty medications)

A medication may be placed in tier 3 or 4 if it is new and not yet proven to be safe or effective; or there is a similar drug on a lower tier of the formulary that may provide you with the same benefit at a lower cost.

Note: If you have a federally qualified High Deductible Health Plan, you do not have a tiered drug benefit – your pharmacy and medical expenses are subject to your deductible and coinsurance. This section does not apply to you. Sometimes, the active ingredients in a generic drug are chemically identical to their brand name counterparts. When the FDA-approved generic is available, a health plan may limit coverage to the generic, and a pharmacist will dispense the generic medication.

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