ESSENTIAL HEALTH BENEFITS:

Health care services that insurance must cover under the Affordable Care Act includes important care you get without being admitted to a hospital or doctor's office, such as hospitalization, pregnancy, mental and/or behavioral health care, prescription drugs, laboratory services, emergency care in an outpatient setting, ambulatory surgical care, and preventive care.

SUMMARY OF BENEFITS & COVERAGE (SBC)

A document that lists the plan's benefits, cost-sharing arrangements, and explanations of benefits. This document is used to easily compare costs, benefits and coverage between different health plans.

Mental Health Parity Act

Mental health parity refers to providing the same insurance coverage for mental health treatment as is offered for medical and surgical treatment. The mental health act, was passed in 1996, and established parity in federal and state benefit plans and annual limits.

ALLOWED AMOUNT:

The maximum amount an insurance company will pay for a covered health service.

COORDINATION OF BENEFITS (COB):

A person used to establish the order in which health insurance plans pay when there are more than one plans costs. Determines which insurance is primary and secondary.

CLAIM:

A paper or electronic request by a provider to an insurance company to pay your medical services.

Explanation of Benefits (EOB):

The health insurance company's written explanation of how a claim was paid. It contains detailed information about what the company accepted and what portion of the costs you are responsible.

COST-SHARING:

The general term that refers to the share of costs for services covered for a plan in health insurance that you must report of your own pocket (sometimes called "out-of-pocket costs.")

Some examples of types of cost-sharing include copayments, deductibles, coinsurance, and out-of-pocket maximum. Other costs to consider include your premiums. Without these premiums, you may have to pay for the cost of care not covered by a plan, which can be a real surprise and costly decision.

IN-PLAN EXPENSES:

The amount of money charged by the insurance company for the plan that is not covered. It is usually paid on a monthly basis (i.e., monthly premium).

OUT-OF-POCKET MAXIMUM:

A dollar amount you or your family can be responsible for after insurance has paid its share of a claim. After the maximum is reached, you are responsible for 100% of the remaining medical costs.

IN-NETWORK PROVIDERS:

A healthcare provider who is part of a plan's network.

OUT-OF-NETWORK PROVIDER:

A healthcare provider who is not part of a plan's network. ( oftentimes with out-of-network providers may be lower than that covered by your plan. Consult your plan for more information.)

SPECIANS:

A specialist physician focusing on a specific area of medicine or a group of conditions, diseases, or illnesses.

PRIMARY PHYSICIAN:

A provider who has special training in a specific area of medicine.

CONTRIBUTIONS:

An individual responsible for any medical expenses incurred on the patient's behalf. This may be the patient's employer, legal guardian, or the patient if 18 or 15 years of age.

MINIMUM:

A person's age at which they are entitled to Medicare. This does not mean the person needs to take Medicare. It is simply the age at which the option is available to them.

MEDICAL Necessity:

Services, supplies or prescription drug that are necessary to diagnose or treat your medical condition. They are services that are considered to be medically necessary.

MEDICAL EQUIPMENT:

Changes for health care services your plan does not cover.

MEDICAL NECSSITY:

A policyholder who pays for a specific insurance plan. If you have insurance through your employer or on your own plan that you identify yourself, then you are the subscriber.

SURENESS:

A government financial assistance that helps pay for insurance purchased on this marketplace.

PARTY (INSURED):

Third parties that may be liable to pay for services for private insurance plans. These may include the insurance company, the policyholder, the employer, or other entities that have an interest in the insurance policy.

AGREEMENT:

Any contract between an employer and an insurance company for the purchase of insurance.

WELFARe:

Insurance plans that are designed to cover catastrophic health care expenses for covered individuals. This is the 2015 Affordable Care Act.