Glossary of Key Health Insurance Terms

ESSENTIAL HEALTH BENEFITS:	Health care services that insurances must cover under the Affordable Care Act. Includes outpatient care you get without being admitted to a hospital, emergency services, hospitalization, pregnancy, maternity and newborn care, mental health, prescription drugs, laboratory services and more.
SUMMARY OF BENEFITS & COVERAGE (SBC)	A document that lists the plan's benefits. It may make it easier to compare costs, benefits and coverage between different health plans. **Also known as:** SBCS, benefits summary
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 treatments. The Mental Health Parity Act was passed in 1996, and established parity in lifetime benefit limits and annual limits.
ALLOWED AMOUNT:	The maximum amount an insurance company will pay for a covered health service.
COORDINATION OF BENEFITS (COB):	A provision used to establish the order in which health insurance plans pay claims when more than one plan exists. Determines which insurance is primary and secondary.
CLAIM:	A paper or electronic request by a plan member's health care provider, for the insurance company to pay for medical services
Explanation of Benefits (EOB)	The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible.

COST SHARING:	The general term that refers to the share of costs for services covered by a plan or health insurance that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of types of cost sharing include copayments, deductibles, and coinsurance. Other costs, including your premiums, penalties you may have to pay or the cost of care not covered by a plan or policy are usually not considered cost sharing.
PREMIUM:	The amount of money charged by your insurance company for the plan you've chosen. It is usually paid on a monthly basis (aka monthly premium)
COPAY:	A fixed amount you pay for a health care service, usually when you receive the service. The amount can vary by the type of service.
DEDUCTIBLE:	The amount you pay for health care services before your insurance begins to pay.
DEPENDENT:	Any individual, either a spouse or child, that is covered by the primary insured member's plan.
OUT-OF-POCKET MAXIMUMS:	A predetermined amount of money you will have to pay during a policy period (usually a year) for health care services. Once you've reached your out-of-pocket maximum, your plan begins to pay 100 percent of the allowed amount for covered services.
IN-NETWORK PROVIDER:	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. Costs associated with out-of-network providers may be higher or not covered by your plan. Consult your plan for more information.
SPECIALIST:	A physician specialist focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A **non-physician specialist** is a provider who has special training in a specific area of health care.

GUARANTOR:	Individual responsible for any medical expenses incurred on the patient's behalf. This may be the patient's parents, legal guardian, or the patient if over 18 or if emancipated.
MINORS:	A person who has not reached the age of adulthood. In most states, a person reaches adulthood and acquires all of the rights and responsibilities of an adult when he or she turns 18 and completes high school (either by graduating or dropping out). Minors (unless emancipated) are not financially responsible for medical debts
NON-COVERED CHARGES:	Charges for health care services your plan does not cover
MEDICAL NECESSITY"	Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:
SUBSCRIBER:	The policyholder who pays for a specific insurance plan. If you have insurance is through your own employer, or it's your own plan that you directly pay, then you are the subscriber.
SUBSIDY:	Government financial assistance that helps you pay for insurance purchased on the marketplace.
THIRD PARTY LIABILITY (TPL):	Third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, longterm care insurance, and other State and Federal programs (unless specifically excluded by Federal statute).
MARKETPLACE:	Internet resource where individuals, families, and small businesses can: learn about their health coverage options; compare commercial health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. A key component of the Affordable Care Act.