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General Insurance Terms

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Affordable Care Act (ACA): The Affordable Care Act (ACA), formally known as the Patient Protection and Affordable Care Act (PPACA) and Obamacare, is a landmark U.S. federal statute enacted by President Obama in 2010.

Benefit Package: The set of services (physician visits, hospitalization, prescription drugs, etc.) that are covered by an insurance policy or health plan.

Claim: A formal request for payment related to an event or situation that is covered under an in-force insurance policy.

Coinsurance: A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy.

Co-Payment: A fixed amount (for example, $50) you pay for a covered health care service, usually when you receive the service.

Covered Benefit: Any service or medical care item covered by a health insurance plan.

Deductible: A dollar amount that a patient must pay for health care services each year before the insurer will begin paying claims under a policy.

Flexible Spending Account (FSA): An FSA is a tax-free financial account set up by an employer for employees to put aside part of their earnings to pay for certain qualified expenses that are not covered by their insurance companies.

Health Insurance Portability Act of 1996 (HIPAA): The federal law allows individuals to move from job to job without the risk of being unable to obtain health insurance or having to wait for coverage due to pre-existing medical conditions.

Health Reimbursement Account (HRA): A tax-exempt account that can be used to pay for current qualified health expenses.

High Deductible Health Plan (HDHP): A type of health insurance plan that requires greater out-of-pocket spending, although premiums may be lower.

In-Network Provider: A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an HMO or PPO).

Medicaid: A joint state and federal program that provides health care coverage to eligible categories of low-income individuals.

Maximum Out-of-Pocket Expense (MOOP): The maximum amount someone covered under a health plan must pay during a certain period for expenses covered by the plan.

Medicare: A federal government program that provides health care coverage for all eligible individuals aged 65 or older or under age 65 with a disability, regardless of income or assets.

Network: All physicians, specialists, hospitals, and other providers who agreed to provide medical care to HMO or other managed care plans members under terms of the contract with the plan.

Open Enrollment Period: An annual period during which individuals may enroll in insurance and/or other benefits.

Out-of-Network Provider: A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization's network (such as an HMO or PPO).

Preferred Provider Organization (PPO): A type of health plan that provides health care coverage through a network of providers.

Premium: The periodic payment required to keep a policy active.

Section 125 Plans (Cafeteria Plan): A cafeteria plan allows employees to receive specified benefits, including health benefits on a pre-tax basis.

Self-Insured Plan: A plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims.

Waiting period: A period of time that an insured must wait before their coverage become effective.