Glossary of Terms

Actuarial Value
A health insurance plan's actuarial value is the percentage of total average costs for benefits that a plan covers. All Covered California health insurance plans have an actuarial value assigned to them: Bronze, Silver, Gold or Platinum. As the metal category increases in value, so does the percent of medical expenses that a health plan covers. This means the Platinum plans cover the highest percentage of health care expenses. These expenses are usually incurred at the time of health care services — when you visit the doctor or the emergency room, for example. The health insurance plans that cover the greatest percentage of health care expenses also usually have higher premium payments.

Advanced Premium Tax Credit (APTC)
Financial assistance eligible consumers may receive when enrolling in a Covered California health insurance plan, to assist them in paying their monthly premium costs. The amount of premium assistance an individual may receive is determined based on his or her income as a percentage of the federal poverty level. This tax credit may also be described as "premium assistance." Tax credits are also available to small businesses with fewer than 25 full-time-equivalent employees to help offset the cost of providing coverage.

Affordable Care Act
Enacted in March 2010, the federal Patient Protection and Affordable Care Act (Affordable Care Act), occasionally referred to as "Obamacare," provides the framework, policies, regulations and guidelines for implementation of comprehensive health care reform by the states. The Affordable Care Act expands access to quality, affordable insurance and health care.

Affordable Coverage
Employer coverage is considered affordable — as it relates to premium assistance from the federal government (also known as the Advanced Premium Tax Credit [APTC]) — if the employee's share of the annual premium for self-only coverage is no greater than 9.5 percent of annual household income. Individuals offered employer-sponsored coverage that's affordable and provides minimum value are not eligible for premium assistance.

Allowed Amount
The amount a health insurance plan and health care provider have agreed on as reimbursement for a service by contract. For example, the provider agrees to accept a set dollar amount as full payment for an office visit.

Ambulatory Patient Services
Medical care provided without need of admission to a health care facility. This includes a range of medical procedures and treatments such as blood tests, X-rays, vaccinations and even monthly well-baby checkups by pediatricians.

Annual Household Income
The total amount of income for a family in a calendar year. The modified adjusted gross income of the household used for tax purposes.

Annual Limit
A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. These caps are sometimes placed on particular services, such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Benefit
Products and services covered under health insurance plans. Covered benefits and excluded services are defined in the insurance products' explanations of coverage.

Bronze plan
Covered California health insurance plans — and all health plans in the individual and small-group markets — are sold in four levels of coverage: Bronze, Silver, Gold and Platinum. As the metal category increases in value, so does the percentage of medical expenses that a health insurance plan covers compared with what you are expected to pay in co-pays and deductibles. On average, Platinum-level plans cover 90 percent of health care costs, and you pay 10 percent; Gold plans cover 80 percent, while you pay 20 percent; Silver plans cover 70 percent, while you pay 30 percent; and Bronze plans cover 60 percent, while you pay 40 percent.

Plans in higher metal categories have higher monthly premiums, but when you need medical care, you pay less. Alternatively, you can choose to pay a lower monthly premium, and when you need medical care, you pay more. You can choose the level of coverage that best meets your health needs and budget.

Carrier
A company that provides health insurance plans.

Certified Insurance Agent
Insurance agents wishing to work with Covered California must possess a valid license through the California Department of Insurance and must complete Covered California's Certified Insurance Agent training and certification program. Covered California's training and certification for insurance agents began in September 2013.

Covered California Certified Insurance Agents assist consumers in receiving eligibility determinations. Agents also work one on one with consumers to help them complete the Covered California application and select and enroll in a health insurance plan in either Covered California's individual market or through its Small Business Health Options Program (SHOP) marketplace. Unlike Certified Enrollment Counselors, Certified Insurance Agents may collect premiums for consumers who are enrolled electronically, but they are prohibited from collecting any premium payments on behalf of consumers who complete the paper application. Certified Insurance Agents provide impartial information about a consumer's plan choices, and they can offer advice about which particular plan may best meet a consumer's needs.

COBRA
A federal law (the Consolidated Omnibus Budget Reconciliation Act) that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100 percent of the premiums, including the share the employer used to pay, plus a small administrative fee.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20 percent) of the allowed amount for the service. You pay coinsurance plus any deductible you owe. For example, if the health insurance plan's allowed amount for an office visit is $100, and you have met your deductible for the year, your coinsurance payment of 20 percent would be $20. The health plan pays the rest of the allowed amount.

Copayment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost-Sharing
The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost-sharing in Medicaid and Children's Health Insurance Program also includes premiums.

Covered California
Covered California™ is the state marketplace established under the Patient Protection and Affordable Care Act that connects Californians to accessible, quality health coverage.

Deductible
The amount you owe for health care services your health insurance plan covers before your plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you have met your deductible for covered health care services. The deductible may not apply to all services.

Dependent
A child or other individual for whom a parent, relative or other person may claim a personal exemption tax deduction. Under the Patient Protection and Affordable Care Act, individuals may be able to get premium assistance to help cover the cost of coverage for themselves and their dependents.

Dependent Coverage
Insurance coverage for family members of the policyholder, such as spouses, children or partners.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Enhanced Silver plan
In some cases, individuals may qualify for an Enhanced Silver plan. This means, based on their income, that when an individual chooses a Silver plan, they have out-of-pocket savings through lower co-pays, co-insurance and deductibles.

Individuals in these categories get the out-of-pocket savings benefit of a Gold or Platinum plan for a Silver plan price. With an Enhanced Silver plan, on average, the plan pays 94 percent, 87 percent or 73 percent of expenses in total for covered benefits, with enrollees responsible for the rest.

Essential Health Benefits
Health care service categories that must be covered by all plans, starting in 2014. These service categories include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; behavioral health treatment; prescription drugs; rehabilitation and habilitation services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including dental and vision care. Insurance policies must cover these benefits in order to be certified and offered in the marketplace, and all Medicaid state plans (Medi-Cal in California) must cover these services by 2014.

Exchange
See "health insurance marketplace."

Exclusive Provider Organization (EPO)
An exclusive provider organization (EPO) is a type of health care doctor and hospital network that offers a full array of covered benefits from a single network. Covered benefits are not paid for services rendered by a doctor or hospital that is not part of the network, except in the case of emergency or plan-approved care outside the network.

Federal Poverty Level
A measure of income level issued annually by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits. In California, for example, Medi-Cal is available to those making up to 138 percent of the federal poverty level.

Formulary
A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Gold plan
Covered California health insurance plans — and all health plans in the individual and small-group markets — are sold in four levels of coverage: Bronze, Silver, Gold and Platinum. As the metal category increases in value, so does the percentage of medical expenses that a health plan covers compared with what you are expected to pay in co-pays and deductibles. On average, Platinum-level plans cover 90 percent of health care costs, and you pay 10 percent; Gold plans cover 80 percent, while you pay 20 percent; Silver plans cover 70 percent, while you pay 30 percent; and Bronze plans cover 60 percent, while you pay 40 percent.

Plans in higher metal categories have higher monthly premiums, but when you need medical care, you pay less. Alternatively, you can choose to pay a lower monthly premium, and when you need medical care, you pay more. You can choose the level of coverage that best meets your health needs and budget.

Guaranteed Issue
A requirement that health insurance plans must permit you to enroll regardless of health status, age, gender or other factors that might predict the use of health services.

Health Coverage
Legal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company; a group health plan offered in connection with employment; or a government program like Medicare, Medicaid (Medi-Cal in California) or the Children's Health Insurance Program (CHIP).

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Health Insurance Marketplaces
Under the Patient Protection and Affordable Care Act, these are resources where individuals, families and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits and other important features; choose a plan; and enroll in coverage. Marketplaces also provide information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the marketplaces, and information about other programs, including Medicaid (Medi-Cal in California) and the Children's Health Insurance Program (CHIP). Marketplaces encourage competition among private health plans and are accessible through websites, call centers and in-person assistance. In some states, such as California, the marketplace is run by the state. In others, it is run by the federal government.

Health Maintenance Organization (HMO)
A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the health maintenance organization (HMO). It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Independent Practice Association (IPA)
An independent practice association (IPA) is a legal entity organized and directed by physicians in private practice to negotiate contracts with health insurance issuers on their behalf.

Inpatient Care
Health care that you get when you're admitted as an inpatient to a health care facility, like a hospital or skilled nursing facility.

Medi-Cal
California's Medicaid health care program. This program provides free medical services for children and adults with limited income and resources. Your local county welfare/social services department manages Medi-Cal eligibility determinations. Visit the Medi-Cal section of this website for more information.

Medi-Cal Access Program (MCAP)
California's Medi-Cal Access Program (MCAP) for pregnant women (formerly known as the Access for Infants and Mothers [AIM] program) provides low-cost, comprehensive health coverage for middle-income pregnant women who do not have health insurance, who are not eligible for Medi-Cal or Medicare Part A and Part B, and who are less than 30 weeks pregnant. This program is administered by the California Department of Health Care Services.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Medicare
A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Minimum Coverage Plan
Covered California health insurance plans — and all health plans in the individual and small-group markets — are sold in four levels of coverage: Bronze, Silver, Gold and Platinum. In addition to these categories, Covered California offers a "minimum coverage plan," also known as a "catastrophic plan," which helps protect a person from financial disaster in the event of a serious and expensive medical emergency. Minimum coverage plans are designed to cover excessive medical bills that occur above the limit that you would be able to manage financially. Covered California offers minimum coverage to those up to age 30 or those individuals who prove they are without affordable coverage options or are experiencing financial hardship.

Network
The facilities, providers and suppliers with whom your health insurer or plan has contracted to provide health care services.

Open Enrollment
A designated period of time each year — usually a few months — during which insured individuals or employees can make changes in health insurance coverage.

Out-of-Pocket Costs
An out-of-pocket expense is a nonreimbursable expense paid by a patient. This could include any medical benefits that a plan doesn't consider "covered services."

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100 percent of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance plan doesn't cover. Some health insurance plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit. In Medicaid and Children's Health Insurance Program, the limit includes premiums.

Patient Protection and Affordable Care Act
Enacted in March 2010, the federal Patient Protection and Affordable Care Act (Affordable Care Act), occasionally referred to as "Obamacare," provides the framework, policies, regulations and guidelines for implementation of comprehensive health care reform by the states. The Affordable Care Act expands access to quality affordable insurance and health care.

Platinum plan
Covered California health insurance plans — and all health plans in the individual and small-group markets — are sold in four levels of coverage: Bronze, Silver, Gold and Platinum. As the metal category increases in value, so does the percentage of medical expenses that a health insurance plan covers compared with what you are expected to pay in co-pays and deductibles. On average, Platinum-level plans cover 90 percent of health care costs, and you pay 10 percent; Gold plans cover 80 percent, while you pay 20 percent; Silver plans cover 70 percent, while you pay 30 percent; and Bronze plans cover 60 percent, while you pay 40 percent.

Plans in higher metal categories have higher monthly premiums, but when you need medical care, you pay less. Alternatively, you can choose to pay a lower monthly premium, and when you need medical care, you pay more. You can choose the level of coverage that best meets your health needs and budget.

Policy
The contract (agreement) between the person buying health insurance and the company providing it, describing specific health care services that are covered, any coverage limitations and any out-of-pocket costs (copays) that might be required.

Pre-Existing Medical Condition
Any illness or condition a patient has prior to obtaining insurance.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Preferred Provider Organization (PPO)
A type of health insurance plan that contracts with participating doctors and hospitals to create a network. You pay less if you use doctors and hospitals that belong to the plan's network. You can use doctors, hospitals and others outside the network for an additional cost.

Premium
The amount that must be paid for your health insurance or plan. You or your employer, or both, usually pay it monthly, quarterly or yearly.

Premium Assistance
See "Advanced Premium Tax Credit."

Preventive Services/Preventive Care
Routine health care that includes screenings, checkups and patient counseling to prevent illnesses, disease or other health problems.

Pricing Region
There are 19 pricing regions in California. For health plans that consumers can get through Covered California, either with or without premium assistance, the plans available and their prices vary by region. The easiest way to find the pricing region you live in is to use our Shop and Compare Tool online. After entering your home ZIP code, the Shop and Compare Tool will show you your pricing region. You may also call our Service Center for assistance.

Primary Care Provider
A physician (medical doctor [M.D.] or doctor of osteopathic medicine [D.O.]), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Qualified Health Plan (QHP)
An insurance product that is certified by a marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments and out-of-pocket maximum amounts) and meets other requirements. A qualified health plan has a certification by each marketplace in which it is sold. All Covered California health insurance plans are qualified health plans.

Qualifying Life Event
A change in your life that can make you eligible for a special enrollment period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income and changes in your family size (for example, if you marry, divorce or have a baby).

Rehabilitative/Rehabilitation Services
Health care services that help you keep, get back or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and outpatient settings.

Silver plan
Covered California health insurance plans — and all health plans in the individual and small-group markets — are sold in four levels of coverage: Bronze, Silver, Gold and Platinum. As the metal category increases in value, so does the percentage of medical expenses that a health plan covers compared with what you are expected to pay in co-pays and deductibles. On average, Platinum-level plans cover 90 percent of health care costs, and you pay 10 percent; Gold plans cover 80 percent, while you pay 20 percent; Silver plans cover 70 percent, while you pay 30 percent; and Bronze plans cover 60 percent, while you pay 40 percent.

Plans in higher metal categories have higher monthly premiums, but when you need medical care, you pay less. Alternatively, you can choose to pay a lower monthly premium, and when you need medical care, you pay more. You can choose the level of coverage that best meets your health needs and budget.

Small Business Health Options Program (SHOP)
Covered California operates a specific program, the Small Business Health Options Program (SHOP), that offers new health insurance choices to small businesses and their employees. The program is designed specifically for employers with 50 and fewer eligible employees to give them unprecedented opportunities to offer a variety of health insurance plans to their employees. Through Covered California, employers and their employees can choose the plans that fit their needs and their budgets.

Special Enrollment
The opportunity for people who experience a life-changing event, such as the loss of a job, death of a spouse or birth of a child, to sign up immediately in a health plan, even if it is outside of the plan's specified enrollment period.

Subsidy
Cost-sharing subsidies and premium assistance reduce the cost of premiums and out-of-pocket expenses for health coverage that qualifying individuals and families purchase through Covered California.

Summary of Benefits and Coverage (SBC)
An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits and other features that may be important to you. You'll get a summary of benefits and coverage (SBC) when you shop for coverage on your own or through your job, renew or change coverage, or request an SBC from the health insurance company.

Tax Credit
See "Advanced Premium Tax Credit."

Tax Household
The taxpayer(s) and any individuals who are claimed as dependents on one federal income tax return. A tax household may include a spouse or dependents.

Tax Penalty
There are penalties for individuals who choose not to get affordable insurance. These penalties are part of the federal law and will be collected by the Internal Revenue Service as part of individual tax filing for 2014. There are no penalties for small employers (fewer than 50 full-time-equivalent employees), but starting in 2015 large employers may be subject to a penalty if they do not offer affordable coverage to their employees.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Well-Baby and Well-Child Visits
Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments.