GLOSSARY

Affordable Care Act	(aka Obama Care)- The name used to refer to the federal health laws that require most Americans to have health insurance that provides Minimum Essential Coverage. The name refers to two distinct pieces of legislation — the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).
Open Enrollment	A period of time every year when people can enroll in a health insurance plan for the next plan year. For individuals and families, the annual open enrollment season is every fall and usually lasts 3 months. If your employer offers health insurance, the open enrollment time will be shorter and at a different time, so you should check with your employer on when you can enroll. You can apply for and enroll in Medicaid any time of the year.
Premiums	A premium is an amount to be paid for an insurance policy. This is typically the monthly cost to pay for insurance coverage.
Deductibles	(in an insurance policy) a specified amount of money that the insured must pay before an insurance company will pay a claim.
Premium Tax Credit	The federal government offers a tax credit to help pay for private health insurance for individuals and families within certain income limits who also meet certain other requirements. The tax credit can either be automatically applied toward your insurance premiums to lower your monthly payment, or you can claim it when you file your federal tax return. You must apply for premium reductions to confirm eligibility and to receive the tax credit.
Copayment	A fixed dollar amount you pay for a covered service, usually when you receive the service. The amount can vary depending on the type of service. (For example, $25 to visit your doctor, $10 for prescription drugs). Once you reach your out-of-pocket limit, you no longer have copays for the rest of the plan year.
Coinsurance	Your share of the costs for covered services that you pay when you receive them. Coinsurance is calculated as a percent of the total fee. For example, if your health insurance plan’s allowed amount to visit your doctor is $100, a coinsurance payment of 20 percent would be $20. Some plans require that you pay up to the plan's deductible amount before coinsurance begins. Once you reach your out-of-pocket limit, you no longer have to pay coinsurance for the rest of the plan year.a
Medicare	A federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). The program helps with the cost of health care, but it doesn't cover all medical expenses or the cost of most long-term care. The program is administered through the Social Security Administration, not through DC Health Link.
Medicaid	A joint federal-state health program that provides health care coverage to low-income and disabled adults, children and families. To be eligible for DC Medicaid, you must be a District resident and must meet non-financial and financial eligibility requirements. Medicaid covers many services, including doctor visits, hospital care, prescription drugs, mental health services, transportation and many other services at little or no cost to the individual. Currently, 1 out of

	every 3 District residents receives quality health care coverage through the Medicaid program.
Assister	Assisters help individuals, families and small businesses in the District find quality, affordable health insurance through DC Health Link. Assisters are trained experts with deep roots and trusted relationships in the District and its communities. They include consumer and patient advocates, civic and faith-based organizations, business leaders and others. Assisters must complete more than 30 hours of rigorous training and pass criminal background checks prior to service. There is no cost to use an Assister
Broker	Brokers are licensed professionals with health insurance expertise and long-standing relationships with Small Business owners, Individuals and Families. Brokers help clients identify their options and make choices that are in their best interest and meet their needs and budget. In the District of Columbia, Brokers must have an active DC license in good standing, complete training on DC Health Link, and have contractual relationships with each carrier in DC Health Link for the market in which he/she intends to sell. There is no cost to use an insurance broker.
American Rescue Plan	The American Rescue Plan Act of 2021 (H.R. 1319) became law on March 11, 2021. The American Rescue Plan includes provisions that lower health insurance premiums for District residents, provide health insurance premiums for as little as $2 per month for those who received unemployment compensation at any point in 2021, and pay 100 percent of COBRA premiums for laid-off workers.
Authorized Representative	Someone you choose to act on your behalf. The person could be a family member, a Broker or other person you trust, or someone who has legal authority to act on your behalf.
Benefit Year	If you sign up for Individual & Family health insurance through DC Health Link, the benefit year is the year when coverage is active. It begins on January 1 and ends on December 31, even if your coverage starts after January 1. Changes to covered services or what you pay for health insurance are made at the beginning of the calendar year. If you sign up for employer-sponsored coverage through DC Health Link, the benefit year begins when your coverage goes into effect and ends when your entire group's benefit year ends, even if you started after your group started. Changes to covered services or what you pay for health insurance are made at the beginning of the calendar year.
Benefits	Another word for covered services.
Brand Name Drug	A prescription drug or over-the-counter medicine that is protected by a patent and is sold by one company under a specific name or trademark.
Catastrophic Health Plan	A health plan with low monthly premiums and high annual deductibles designed to protect consumers from worst case situations like a serious illness or an accident. Catastrophic plans are only available to people under 30 or people with a hardship exemption. Catastrophic plans provide essential health benefits and count as having coverage for tax purposes. Plans cover at least 3 primary care visits during the plan year and certain preventive services at no cost. Consumers pay all other medical costs until the annual deductible is met. Then the plan pays 100 percent for covered services for the rest of the plan year. Advance premium tax credits and cost-sharing reductions can't be used with this plan type.
Carrier	An insurance company.

Children's Health Insurance Program (CHIP)	An insurance program that provides no cost or low cost health coverage to children in families that earn too much money to qualify for Medicaid but not enough to buy private health insurance. In the District of Columbia, you can apply for CHIP coverage any time of the year through the Medicaid program.
Claim	A request for payment submitted by you or your service provider to your insurance company for covered services received or rendered.
Consolidated Omnibus Budget Recognition Act (COBRA)	A federal law that may allow you to keep employer-sponsored health insurance if you lose your job. In most cases, you'll pay the full costs every month plus a small administrative fee if you elect to continue the coverage. COBRA coverage is typically available up to 18 months (longer only in special circumstances).
Coinsurance	Your share of the costs for covered services that you pay when you receive them. Coinsurance is calculated as a percent of the total fee. For example, if your health insurance plan's allowed amount to visit your doctor is $100, a coinsurance payment of 20 percent would be $20. Some plans require that you pay up to the plan's deductible amount before coinsurance begins. Once you reach your out-of-pocket limit, you no longer have to pay coinsurance for the rest of the plan year.
Copayment	A fixed dollar amount you pay for a covered service, usually when you receive the service. The amount can vary depending on the type of servicefor example, $25 to visit your doctor, $10 for prescription drugs). Once you reach your out-of-pocket limit, you no longer have copays for the rest of the plan year.
Cost-Sharing Reductions	A discount that lowers your costs for deductibles, coinsurance, copayments, and also lowers what you have to pay to reach your out-of-pocket limit. To get these savings, you must apply for financial assistance. DC Health Link will help you determine if you qualify as part of the application process. Then you can enroll. Most customers must enroll in a Silver Health Plan to receive cost-sharing reductions. Native Americans receive additional cost-sharing reductions regardless of a plan's metal level.
Coverage	Another word for health insurance, Medicaid or a dental plan.
Covered Services	The health care services you're entitled to receive based on the terms of your health insurance plan. All plans available through DC Health Link cover essential health benefits. Other covered services or excluded services will vary among plans. Each plan available through DC Health Link includes a Summary of Benefits and Coverage, but it's only a summary. You'll need to see your plan documents for all benefits information. You can also call the insurance company directly if you have questions.
DC Health Link	The District of Columbia's system for individuals, families, small businesses and their employees as well as members of Congress and their staff to access health and dental coverage through private health companies or Medicaid.
DC Healthcare Alliance Program	A managed care health plan that provides medical assistance to District of Columbia residents who are not eligible for Medicaid. The Alliance serves low-income District residents who have no other health insurance and are not eligible for either Medicaid or Medicare. The program is sponsored and paid for by the District government. Learn more about eligibility for the DC Healthcare Alliance Program.
DC-Metro Network	A designation that indicates the plan's network of doctors, specialists, other providers, facilities and suppliers that plan members can access is limited to the DC metropolitan area.

Employer-Sponsored Health Insurance	Coverage offered to an employee by an employer (also called job-based coverage). At the employer's option, it may include family coverage. Typically, employers make a contribution towards the costs of your premiums, and usually you'll have a choice of plans. You pay your share of the premium costs directly to your employer - typically through payroll deductions.
Essential Health Benefits	All health insurance plans available through DC Health Link are required by federal law to include what are called essential health benefits. These include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitation services and habilitative services and devices; laboratory services; preventive services and chronic disease management; and pediatric services, including dental and vision care for children. This doesn't mean that all plans are the same. Some plans may offer a higher level of service or additional services beyond the minimum required, or exclude other optional services that may be important to you. It's important to understand these differences when comparing and choosing a plan to meet your needs and budget.
Exchange	Another word for a Health Insurance Marketplace, also known as the DC Health Link
Federal Poverty Level	A measure of income used to determine eligibility for certain financial assistance programs. The guidelines are issued each year by the US Department of Health and Human Services. Learn more about this year's FPL guidelines. https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines
Generic Drugs	A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand name drugs.
Group Health Plan	An umbrella term generally used to describe a health plan offered by either an employer or an employee organization (such as a union) that provides medical coverage to plan participants.
Healthcare.gov	The website for the federally-facilitated health insurance marketplace used by many states to help meet the provisions of the Affordable Care Act. The District of Columbia operates its own health insurance marketplace accessible through DC Health Link; however, District residents who need an exemption from having health insurance apply for it through healthcare.gov
Health Saving Account	If you have a High Deductible Health Plan, you may be eligible for a Health Savings Account (HSA) where you (and if applicable, your employer) can deposit pre-tax dollars to pay for qualified medical expenses like your deductible, copayments and coinsurance. There's an annual limit on contributions established by the IRS, but any funds deposited can be used in future years. If you have an HSA through your employer, the funds belong to you and can rollover into another qualifying account if you ever leave.
High Deductible Health Plan	A feature of some health plans. HDHPs have a higher annual deductible and typically lower monthly premiums. You pay more for health care up front before your insurance company starts to pay. With an HDHP, you're eligible to open a tax deductible Health Savings Account or Health Reimbursement Arrangement to pay for qualified medical expenses like your annual deductible, copayments or coinsurance. The IRS defines the limits for plans that qualify as HDHPs and the deductible and out-of-pocket limit may be adjusted annually for inflation.
Immigrant Children's Program	A health coverage program available to children under the age of 21 who aren't eligible for Medicaid due to citizenship or immigration status. Learn more about the District's Immigrant Children's Program.

In-Network	The service providers and suppliers your health insurance company has contracted with to provide health care services. Some health insurance plans will only let you use in-network (sometimes called “preferred”) service providers, and only cover out-of-network providers on a limited basis. It also costs less to use in-network service providers. If you have a doctor or other service provider that you want to keep using, make sure they are in-network for the health insurance plan you choose.
Inpatient Care	Medical care received after formally being admitted to a hospital or medical facility on a doctor's order. Inpatient care includes services like room, board and nursing care and typically requires an overnight stay. Inpatient care is usually more expensive than outpatient care, and may require pre-authorization from your insurance company unless it's an emergency.
IRS Form 1095-A	A federal tax form, also called the Health Insurance Marketplace Statement, that shows how long you had individual (or family) health insurance through a health insurance marketplace during the tax year. If you received an advance premium tax credit to help pay for your insurance, Form 1095-A will also show how much premium assistance you received each month. If you received premium assistance, you’ll need the information on Form 1095-A to complete the Premium Tax Credit IRS Form 8962. DC Health Link will mail your Form 1095-A at the end of January. You can also Download Form 1095-A in early February.
IRS Form 1095-B	A federal tax form sent to the IRS and to taxpayers who either had Medicaid, CHIP or employer-sponsored coverage. Medicaid and CHIP beneficiaries in the District of Columbia receive the form from DC Health Link by the end of January. Employees receive the form directly from their insurance company. The form shows how long you had minimum essential coverage during the tax year.
IRS Form 8962	If you were eligible for and want to claim a premium tax credit, or received an advance premium tax credit to lower your monthly premium, you must file Form 8962 with your federal tax return. The form is used to reconcile your tax credit, comparing the amount you received in advance, and the amount for which you’re actually eligible. This may result in an additional credit, or you may have to repay some or all of the tax credit you received. Form 1095-A provides the information needed to complete this form.
IRS Form 8965	A federal tax form that must be filed with your tax return if you received a health coverage exemption or if you're claiming a coverage exemption on your return. Form 8965 is also used to calculate the penalty for not having coverage (known as the Individual Shared Responsibility Payment) that you must pay if you don't qualify for an exemption.
Katie Beckett Program	An eligibility pathway for the District’s Medicaid Program for certain children who have long-term disabilities or complex medical needs and live at home. Also known as the Tax Equity Fiscal Responsibility Act (TEFRA).
Modified Adjusted Gross Income	The way your income is calculated to see whether or not you qualify for Medicaid or an advance premium tax credit. MAGI is your household's Adjusted Gross Income (as calculated when you file your taxes) plus any non-taxable Social Security benefits, tax-exempt interest, and foreign income.
Nationwide Network	A designation that indicates the plan's network of doctors, specialists, other service providers, facilities and suppliers that plan members can access is national.
Navigator	The DC Health Link Navigator Program is a partnership with community organizations that have experience successfully reaching, educating, and enrolling the District’s diverse uninsured and hard-to-reach populations into Qualified Health Plans (QHPs) and insurance affordability programs. The

	program also provides effective post-enrollment and renewal support services to consumers, as appropriate.
Network	Doctors, specialists, other service providers, facilities and suppliers that a health insurance company contracts with to provide health care services to plan members.
Out-of-Network	Some plans allow you to use out-of-network service providers (sometimes called “non-preferred providers” or a “tiered network”), but you have to pay more to use them. If your plan allows you to go out-of-network, there may be an additional deductible, copayments and coinsurance and an out-of-pocket limit that apply to any out-of-network services you use. If an out-of-network provider charges more than the allowed amount for covered services, you may be responsible for paying the difference (balance billing). It also may not count towards your out-of-network deductible or out-of-pocket limit.
Out-of-Pocket Costs	Expenses you incur for medical services that your insurance company doesn't pay including deductibles, copayments, coinsurance, balance billing along with any costs you incur for excluded services.
Out-of-Pocket Limit	The most you'll have to pay in a plan year for covered services before your health insurance company pays 100 percent. After you spend this amount on deductibles, copayments, and coinsurance, your health insurance pays 100 percent of the allowed amount for covered services. Premiums don't count towards your out-of-pocket limit. also referred to as out-of-pocket maximum.
Outpatient Care	Diagnosis or treatment in a hospital or medical facility that typically doesn't include an overnight stay. Examples include but aren't limited to emergency room services; lab tests or x-rays.
Plan Match	DC Health Link's health plan comparison tool powered by Consumers' CHECKBOOK. Plan match helps you compare and choose a plan based on the features that are most important to you. See Plan Match for Individuals & Families or Plan Match for Small Businesses & Employees. https://www.dchealthlink.com/plan-match
Plan Type	Plan type impacts which doctors you can see, whether or not you can use out-of-network providers or providers outside of your service area, and how much you'll pay. Plan types available through DC Health Link include: Health Maintenance Organizations; Exclusive Provider Organizations; Preferred Provider Organizations; and Point of Service Plans.
Point-of-Service Plan	A type of health plan that's a combination of a Health Maintenance Organization and a Preferred Provider Organization Plan. Typically, it has a network that functions like a HMO – you pick a primary care physician, who manages and coordinates your care in-network. Similar to a PPO, you can use an out-of-network service provider with a referral.
Pre-Authorization	Approvals required by your insurance company prior to receiving some services. Your plan documents spell out which services require pre-authorization. Failure to obtain it may mean your insurance company won't help pay for the service or procedure. For in-network care, your doctor will typically obtain any required approvals. For out-of-network care, you may have to obtain the approvals yourself.
Pre-Existing Condition	A health problem you had before your health coverage begins. Under the Affordable Care Act, health insurance companies can’t refuse to cover you or charge you more just because you have a pre-existing condition.

Preventive Services	Health care to prevent or detect illness or other health problems at an early stage, when treatment is likely to work best. All health plans available through DC Health Link include certain preventive services at no cost to you. When you use DC Health Link's Plan Match tool, you'll find information on preventive services included in your plan when you select the 'Plan Details' page.
Primary Care Physician	A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient. Some health plans require that you select an in-network primary care physician for routine care and coordination of any specialized care.
Private Health Insurance	Health insurance offered by an employer, purchased through an insurance company or through a health insurance marketplace like the private plans available through DC Health Link.
Referral	A written recommendation from a doctor for you to see a specialist or get certain medical services. Some health plans require you to have a primary care physician and get a written referral before you can get medical care from anyone else (except in an emergency). If you don't get a referral first, the plan may not pay for the services.
Refugee Cash Assistance Program	This District's Office of Refugee Resettlement serves to transition District of Columbia Refugees from dependency on public assistance to self-sufficiency. Cash assistance is one of many services offered to refugees in the District. Learn more about refugee assistance in the District of Columbia.
Standard Plan	A standard plan covers many in-network medical services without you having to meet the deductible first. This includes primary care visits, specialist visits, mental health services, generic prescription drugs, and urgent care. Each health insurance company in the Individual & Family market offers a standard plan at each metal level. These plans have the same out-of-pocket costs for an in-network provider. For example, a primary care visit will have a $40 copay for any silver standard plan, whether you choose CareFirst BlueCross BlueShield or Kaiser Permanente. This makes it easier to compare plans. The major differences between standard plans at the same metal level are monthly premiums and provider networks. Note: If you choose an HSA high deductible health plan, you'll still need to meet the deductible first because of IRS rules.
Step Therapy	A form of pre-authorization some plans apply to certain prescription drugs to control risks and costs where the safest, most cost effective drug for a medical condition is prescribed first, before treatment can be "stepped up" with more expensive and/or riskier drugs.
Subsidy	An informal name for the advance premium tax credit or cost-sharing reductions.
Summary of Benefits and Coverage	All plans available through DC Health Link include a short, plain language PDF document that provides an overview of covered services, excluded services, a short glossary of terms, deductibles, copayments and coinsurance for in-network and out-of-network services. The SBC is standardized so that you can make an apples-to-apples comparison among plans, and includes what the plan will pay in two common medical situations. You can find the SBC on the 'Plan Details' page when using DC Health Link's Plan Match tool.
SNAP Supplemental Nutrition Assistance Program	A federal program that provides cash assistance for food, clothing and shelter for disabled or blind adults, children, and people 65 years or older without disabilities who have limited income or resources. This is not the same as social security retirement or disability benefits, and some people may qualify for both. Learn more about how to apply for SSI
Special Enrollment Period	Outside the open enrollment season, you can enroll in a health insurance plan only if you qualify for a special enrollment. You qualify if you have certain

	qualifying life events, like moving to the District, getting married, having a baby, losing other health coverage and other circumstances.
Specialist	A service provider with medical expertise, education and training in a particular practice area. Examples include: dermatologists, ear/nose/throat specialists, oncologists and cardiologists. Some health plans require a referral from your primary care physician to see a specialist.
Temporary Cash Assistance for Needy Familie	Provides cash assistance to needy families with dependent children when available resources do not fully address the family's needs and while preparing program participants for independence through work. Learn more about financial and technical eligibility requirements for District residents.