Glossary of Terms

Actuarial Value
The percentage of total average costs for covered benefits that a plan will cover.

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.

Attest/Attestation
When you apply for health coverage through the Marketplace, you're required to agree (or "attest") to the truth of the information provided by signing the application.

Adjusted Gross Income
Your total (or “gross”) income for the tax year, minus certain adjustments you’re allowed to take. Adjustments include deductions for conventional IRA contributions, student loan interest, and more. Adjusted gross income appears on IRS Form 1040, line 7.

Affordable Coverage Allowed Amount
The maximum amount a plan will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

Appeal
A request for your health insurance company or the Health Insurance Marketplace to review a decision that denies a benefit or payment. If you don't agree with a decision made by the Marketplace, you may be able to file an appeal. Small businesses can also appeal Small Business Health Options Program (SHOP) decisions. If your health plan refuses to pay a claim or ends your coverage, you have the right to appeal the decision and have it reviewed by a third party.

Authorized Representative
A legal proceeding by which a case is brought before a higher court for review of the decision of a lower court

Advance Premium Tax Credit (APTC)
A tax credit you can take in advance to lower your monthly health insurance payment (or “premium”). When you apply for coverage in the Health Insurance Marketplace, you estimate your expected income for the year. If you qualify for a premium tax credit based on your estimate, you can use any amount of the credit in advance to lower your premium. If at the end of the year you’ve taken more premium tax credit in advance than you’re due based on your final income, you’ll have to pay back the excess when you file your federal tax return. If you’ve taken less than you qualify for, you’ll get the difference back.

Glossary of Terms

Agent (or Insurance Agent)
A person employed to sell insurance policies.

Application ID
Each Marketplace application has a unique identification number, or Application ID. After you apply for Marketplace coverage, you'll get a notice with your eligibility results that contains your Application ID. You'll need your Application ID to continue with an existing application, compare plans, and complete enrollment. If you are doing this by phone, you can provide your Application ID to the Marketplace Call Center representative so they can find your application faster. If you're continuing your application, comparing plans, and enrolling online, you'll be asked to enter your Application ID after you log in to your account and select "Find my existing application."

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Bronze Health Plan
Is a plan category in the Affordable Care Act marketplace. This plan category describes individual health insurance plans with the least expensive premiums and the highest copays and coinsurance amounts. Additionally, bronze health plans often have high deductibles.

Beneficiary
A person who derives advantage from something, especially a trust, will, or life insurance policy.

Benefit Period Benefit
A year of benefits coverage under an individual health insurance plan. The benefit year for plans bought inside or outside the Marketplace begins January 1 of each year and ends December 31 of the same year. Your coverage ends December 31 even if your coverage started after January 1. Any changes to benefits or rates to a health insurance plan are made at the beginning of the calendar year.

Benefits
Something that produces good or helpful results or effects or that promotes well-being.

Brand Name Drugs
A drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand name drugs may be available by prescription or over the counter.

Glossary of Terms

Broker (or Insurance Broker)
An agent or broker is a person or business who can help you apply for help paying for coverage and enroll in a Qualified Health Plan (QHP) through the Marketplace. They can make specific recommendations about which plan you should enroll in. They're also licensed and regulated by states and typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer's plans. Some brokers may only be able to sell plans from specific health insurers.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
A federal law 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 (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Care Coordination
The organization of your treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care.

Catastrophic Health Plan
Health plans that meet all of the requirements applicable to other Qualified Health Plans (QHPs) but that don't cover any benefits other than 3 primary care visits per year before the plan's deductible is met. The premium amount you pay each month for health care is generally lower than for other QHPs, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher. To qualify for a Catastrophic plan, you must be under 30 years old OR get a "hardship exemption" because the Marketplace determined that you're unable to afford health coverage.

Centers for Medicare & Medicaid Services (CMS)
The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace.

Certified Application Counselor
An individual (affiliated with a designated organization) who is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers.

Children's Health Insurance Program (CHIP) (Known in Florida as Florida KidCare)
Claim CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP covers pregnant women. Each state offers CHIP coverage and works closely with its state Medicaid program.

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Coinsurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

Coordination of Benefits
A way to figure out who pays first when 2 or more health insurance plans are responsible for paying the same medical claim.

Copayment (Copay)
A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible and can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Let's say your health insurance plan's allowable cost for a doctor's office visit is $100. Your copayment for a doctor visit is $20.

- If you've paid your deductible: You pay $20, usually at the time of the visit.
- If you haven't met your deductible: You pay $100, the full allowable amount for the visit.

Generally, plans with lower monthly premiums have higher copayments. Plans with higher monthly premiums usually have lower copayments.

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 CHIP also includes premiums.

Cost Sharing Reduction
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 CHIP also includes premiums.

(CSR) Creditable Coverage
Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); Children’s Health Insurance Program (CHIP); or, a state health insurance high risk pool. If you have prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage.

Glossary of Terms

Deductible (to include Pharmacy deductible)
The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

Dental Coverage
Benefits that help pay for the cost of visits to a dentist for basic or preventive services, like teeth cleaning, X-rays, and fillings. In the Marketplace, dental coverage is available either as part of a comprehensive medical plan, or by itself through a "stand-alone" dental plan.

Department of Health and Human Services (HHS) Dependent
the federal agency that oversees CMS, which administers programs for protecting the health of all Americans, including Medicare, the Marketplace, Medicaid, and the Children's Health Insurance Program (CHIP).

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

Domestic Partnership
Two people of the same or opposite sex who live together and share a domestic life but aren't married or joined by a civil union. In some states, domestic partners are guaranteed some legal rights, like hospital visitation.

Donut Hole, Medicare Prescription
Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

Drug
Also called a medication or medicine, is a chemical substance used to treat, cure, prevent, or diagnose a disease or to promote well-being.

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

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Glossary of Terms

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

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

Employer or Union Retiree Plans
Plans that provide health and/or drug coverage to former employees or members, and, in some cases, their families. These plans are offered to people through their (or a spouse's) former employer or employee organization. Many of these plans aren't legally required to meet many of the provisions of the Affordable Care Act, including providing coverage for children up to age 26.

Employer Sponsored Insurance
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

(ESI) Essential Health Benefits
A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more. Some plans cover more services. Plans must offer dental coverage for children. Dental benefits for adults are optional. Specific services may vary based on your state's requirements. You'll see exactly what each plan offers when you compare plans.

Exchange
Another term for the Health Insurance Marketplace, a service available in every state that helps individuals, families, and small businesses shop for and enroll in affordable medical insurance. The Marketplace is accessible through websites, call centers, and in-person assistance. When you fill out a Marketplace application, you'll find out if you qualify to save money when you enroll in a medical insurance plan. You'll also find out if you qualify for Medicaid and the Children's Health Insurance Program (CHIP). Whether you qualify for these programs depends on your expected income, household members, and other information.

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

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Exclusive Provider Organization (EPO)
A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

Plan Federal Poverty Level (FPL)
A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

Federally Facilitated Marketplace
Shorthand for the "Health Insurance Marketplace," a shopping and enrollment service for medical insurance created by the Affordable Care Act in 2010.In most states, the federal government runs the Marketplace (sometimes known as the "exchange") for individuals and families. On the web, it's found at HealthCare.gov. Some states run their own Marketplaces at different websites.

Fee for Service
A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Flexible Spending Account
An arrangement through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Allowed expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices.

(FSA) Florida KidCare
CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP covers pregnant women. Each state offers CHIP coverage and works closely with its state Medicaid program.

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.

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.

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Gold Health Plan
One of 4 health plan categories (or “metal levels”) in the Health Insurance Marketplace. Gold plans usually have higher monthly premiums but lower costs when you get care. Gold may be a good choice if you use a lot of medical services or would rather pay more up front and know that you’ll pay less when you get care.

Grace Period
A short period — usually 90 days — after your monthly health insurance payment is due. If you haven't made your payment, you may do so during the grace period and avoid losing your health coverage.

Grievance
A complaint that you communicate to your health insurer or plan.

Group Health Plan
In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

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, 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 Marketplace
A service that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace, available at HealthCare.gov, for most states. Some states run their own Marketplaces. The Health Insurance Marketplace (also known as the “Marketplace” or “exchange”) provides health plan shopping and enrollment services through websites, call centers, and in-person help. Small businesses can use the Small Business Health Options Program (SHOP) Marketplace to provide health insurance for their employees.

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Your status once you have had 18 months of continuous creditable health coverage. To be HIPAA (Health Insurance Portability and Accountability Act) eligible, at least the last day of your creditable coverage must have been under a group health plan; you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you're buying individual health insurance, HIPAA eligibility gives you greater protections than you would otherwise have under state law.

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 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.

Health Reimbursement Account (HRA)
Health Reimbursement Accounts (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements.

Health Savings Account (HSA)
A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account (HSA) to pay for deductibles, copayments, coinsurance, and some other expenses, you can lower your overall health care costs. An HSA can be used only if you have a High Deductible Health Plan (HDHP) — generally any health plan (including a Marketplace plan) with a deductible of at least $1,350 for an individual or $2,700 for a family. When you view plans in the Marketplace, you can see if they’re "HSA-eligible."

Home Health Care
Health care services a person receives at home.

Home and Community-Based Services (HCBS)
Services and support provided by most state Medicaid programs in your home or community that gives help with such daily tasks as bathing or dressing. This care is covered when provided by care workers or, if your state permits it, by your family.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

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Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

Hospital Readmissions
A situation where you were discharged from the hospital and wind up going back in for the same or related care within 30, 60 or 90 days. The number of hospital readmissions is often used in part to measure the quality of hospital care, since it can mean that your follow-up care wasn't properly organized, or that you weren't fully treated before discharge.

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.

Household
The Marketplace generally considers your household to be you, your spouse if you're married, and your tax dependents. Your eligibility for savings is generally based on the income of all household members, even those who don't need insurance.

Indian Health Services (IHS)
An agency within the Department of Health and Human Services that is responsible for providing federal health services to American Indians and Alaska Natives. It is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for American Indians and Alaska Natives.

Individual Health Insurance Policy
Policies for people that aren't connected to job-based coverage. Individual health insurance policies are regulated under state law.

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.

Institution
A facility or establishment in which people (such as the sick or needy) live and receive care.

Insurance Contract
An insurance contract is a document representing the agreement between an insurance company and the insured. Central to any insurance contract is the insuring agreement, which specifies the risks that are covered, the limits of the policy, and the term of the policy.

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Insurance Plan
The plan typically comes with costs such as a monthly premium, an annual deductible, copayments, and coinsurance. Depending on how many plans are offered in your area, you may find plans of all or any of these types at each metal level – Bronze, Silver, Gold, and Platinum. Some examples of plan types you'll find in the Marketplace:

- Exclusive Provider Organization (EPO): A managed care plan where services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency).
- 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 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.
- Point of Service (POS): A type of plan where you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans require you to get a referral from your primary care doctor in order to see a specialist.
- Preferred Provider Organization (PPO): A type of health plan where you pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

Insurance Policy
A document detailing the terms and conditions of a contract of insurance.

Large Group Health Plan
In general, a group health plan that covers employees of an employer that has 51 or more employees. In some states large groups are defined as 101 or more.

Lifetime Limit
A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like a $200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

Long-Term Care
Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.

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Maximum Out of Pocket (MOOP)
The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn't include your monthly premiums. It also doesn't include anything you spend for services your plan doesn't cover. For the 2019 plan year: The out-of-pocket limit for a Marketplace plan is $7,900 for an individual plan and $15,800 for a family plan.

Medicaid
Insurance program that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Many states have expanded their Medicaid programs to cover all people below certain income levels. Whether you qualify for Medicaid coverage depends partly on whether your state has expanded its program. Medicaid benefits, and program names, vary somewhat between states. You can apply anytime. If you qualify, your coverage can begin immediately, any time of year.

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

Medicare Advantage (Medicare Part C)
A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Prescription Drug Plan (Medicare Part D)
A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Medicare Prescription Drug Donut Hole
Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

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Minimum Essential Coverage (MEC)
Any insurance plan that meets the Affordable Care Act requirement for having health coverage. To avoid the penalty for not having insurance for plans 2018 and earlier, you must be enrolled in a plan that qualifies as minimum essential coverage (sometimes called "qualifying health coverage"). Examples of plans that qualify include: Marketplace plans; job-based plans; Medicare; and Medicaid & CHIP.
Note: Starting with the 2019 plan year (for which you'll file taxes in April 2020), the penalty no longer applies.

Minimum Value
A standard of minimum coverage that applies to job-based health plans. If your employer's plan meets this standard and is considered "affordable," you won't be eligible for a premium tax credit if you buy a Marketplace insurance plan instead.

A health plan meets the minimum value standard if both of these apply:

- It's designed to pay at least 60% of the total cost of medical services for a standard population
- Its benefits include substantial coverage of physician and inpatient hospital services

Modified Adjusted Gross Income (MAGI)
The figure used to determine eligibility for premium tax credits and other savings for Marketplace health insurance plans and for Medicaid and the Children's Health Insurance Program (CHIP). MAGI is adjusted gross income (AGI) plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest.

- For many people, MAGI is identical or very close to adjusted gross income.
- MAGI doesn't include Supplemental Security Income (SSI).
- MAGI does not appear as a line on your tax return.

Navigator
An individual or organization that's trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

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

Network Plan
A health plan that contracts with doctors, hospitals, pharmacies, and other health care providers to provide members of the plan with services and supplies at a discounted price.

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Network Provider (In-network Provider)
An in-network provider is one contracted with the health insurance company to provide services to plan members for specific pre-negotiated rates.

New Plan
As used in connection with the Affordable Care Act: A health plan that is not a grandfathered health plan and therefore subject to all of the reforms in the Affordable Care Act. In the individual health insurance market, a plan that your family is purchasing for the first time will generally be a new plan.
In the group health insurance market, a plan that your employer is offering for the first time will generally be a new plan. Please note that new employees and new family members may be added to existing grandfathered group plans – so a plan that is "new to you" and your family may still be a grandfathered plan.

Non-preferred provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Non-network Provider (Out-of-network Provider)
An out-of-network provider is one which has not contracted with your insurance company for reimbursement at a negotiated rate. Some health plans, like HMOs and EPOs, do not reimburse out-of-network providers at all (except in emergency situations), which means that as the patient, you would be responsible for the full amount charged by your doctor if they're not in your insurer's network. Other health plans offer coverage for out-of-network providers, but your patient responsibility would be higher than it would be if you were seeing an in-network provider.

Open Enrollment Period
The yearly period when people can enroll in a health insurance plan typically from November 1st through December 15th. Open Enrollment for 2019 is over, but you may still be able to enroll in a Marketplace health insurance plan for 2019 if you qualify for a Special Enrollment Period.
You're eligible if you have certain life events, like getting married, having a baby, or losing other health coverage.

- Job-based plans may have different Open Enrollment Periods. Check with your employer.
- You can apply and enroll in Medicaid or the Children's Health Insurance Program (CHIP) any time of year

Note: The December 2018 ruling by a Texas federal court doesn't impact current 2019 coverage, any savings you're getting, or your ability to enroll in Marketplace coverage. You can continue to use your coverage and its benefits as long as you pay your premiums.

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Out-of-Pocket Costs
Expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Outpatient Care
Medical care or treatment that does not require an overnight stay in a hospital or medical facility.

Patient Protection and Affordable Care Act
The first part of the comprehensive health care reform law enacted on March 23, 2010.
The law was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is usually used to refer to the final, amended version of the law. (It’s sometimes known as “PPACA,” “ACA,” or “Obamacare.”) The law provides numerous rights and protections that make health coverage more fair and easy to understand, along with subsidies (through “premium tax credits” and “cost-sharing reductions”) to make it more affordable. The law also expands the Medicaid program to cover more people with low incomes.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Plan ID
Each Marketplace health plan has a unique 14-character identifier that's a combination of numbers and/or letters. You can find a plan's ID below the plan name when you preview plans and prices. If you’ve already enrolled in a plan, you'll find your plan's ID in your Marketplace account under "My Plans and Programs."
Note: Your Plan ID is different from your Application ID.

Plan Year
A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies this 12-month period is called a “policy year”).

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Platinum Health Plan
One of 4 categories (or "metal levels") of Health Insurance Marketplace plans. Platinum plans usually have the highest monthly premiums of any plan category but pay the most when you get medical care. They may work well if you expect to use a great deal of health care and would rather pay a higher premium and know nearly all other costs are covered.

Point of Service (POS) Plans
A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

Policy Year
A 12-month period of benefits coverage under an individual health insurance plan. This 12-month period may not be the same as the calendar year. To find out when your policy year begins, you can check your policy documents or contact your insurer. (Note: In group health plans, this 12-month period is called a "plan year").

Pre-Existing Condition
A health problem, like asthma, diabetes, or cancer, you had before the date that new health coverage starts. Insurance companies can't refuse to cover treatment for your pre-existing condition or charge you more.

Preferred Drug
These are brand-name drugs that are not included on the plan's formulary (list of preferred prescription drugs). Non-preferred brand-name drugs have higher coinsurance than preferred brand-name drugs. You pay more if you use non-preferred drugs than if you opt for generics and preferred brand-name drugs.

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 plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Glossary of Terms

Premium
The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance. If you have a Marketplace health plan, you may be able to lower your costs with a premium tax credit.
When shopping for a plan, keep in mind that the plan with the lowest monthly premium may not be the best match for you. If you need much health care, a plan with a slightly higher premium but a lower deductible may save you a lot of money.
After you enroll in a plan, you must pay your first premium directly to the insurance company — not to the Health Insurance Marketplace.

Premium Tax Credit
A tax credit you can use to lower your monthly insurance payment (called your "premium") when you enroll in a plan through the Health Insurance Marketplace. Your tax credit is based on the income estimate and household information you put on your Marketplace application.
If your estimated income falls between 100% and 400% of the federal poverty level for your household size, you qualify for a premium tax credit.

You can use all, some, or none of your premium tax credit in advance to lower your monthly premium.

- If you use more advance payments of the tax credit than you qualify for based on your final yearly income, you must repay the difference when you file your federal income tax return.
- If you use less premium tax credit than you qualify for, you'll get the difference as a refundable credit when you file your taxes.
- You can buy health insurance through other sources, but the only way to get a premium tax credit is through the Health Insurance Marketplace.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications. All Marketplace plans cover prescription drugs.

Prescription Drugs
Drugs and medications that, by law, require a prescription.

Primary Care
Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with you and advise and treat you on a range of health related issues. They may also coordinate your care with specialists.

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.

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Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), 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.

Prior Authorization (Preauthorization)
Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Provider (Healthcare Provider)
A doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner. A health care provider also is any provider from whom the employee's group health plan will accept medical certification to substantiate a claim for benefits.

Public Health
A field that seeks to improve lives and the health of communities through the prevention and treatment of disease and the promotion of healthy behaviors such as healthy eating and exercise.

Qualifying Life Event (QLE)
A change in your situation — like getting married, having a baby, or losing health coverage — that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the yearly Open Enrollment Period. There are 4 basic types of qualifying life events. (The following are examples, not a full list.)

- Loss of health coverage
    - Losing existing health coverage, including job-based, individual, and student plans
    - Losing eligibility for Medicare, Medicaid, or CHIP
    - Turning 26 and losing coverage through a parent’s plan
- Changes in household
    - Getting married or divorced
    - Having a baby or adopting a child
    - Death in the family
- Changes in residence
    - Moving to a different ZIP code or county
    - A student moving to or from the place they attend school
    - A seasonal worker moving to or from the place they both live and work
    - Moving to or from a shelter or other transitional housing
- Other qualifying events

- Changes in your income that affect the coverage you qualify for
- Gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder
- Becoming a U.S. citizen
- Leaving incarceration (jail or prison)
- AmeriCorps members starting or ending their service

Quality Ratings (or 'star' ratings)
Ratings of health plan quality used in the Health Insurance Marketplace, shown as 1 to 5 stars on plan information pages.

- For the 2019 plan year, Michigan, Montana, New Hampshire, Virginia, and Wisconsin are presenting health insurance quality ratings on HealthCare.gov.
- Results from this pilot will be used to improve the program in the future.

Each health plan has an “Overall” quality rating, which is based on scores for 3 elements: member experience, medical care, and plan administration. The plans provided information to the Marketplace in 2018. The Marketplace confirmed the data and assigned the ratings.
In some cases — like when plans are new or have low enrollment — ratings aren’t available.

Reconcile
How you find out if you used the right amount of premium tax credit during the year. To reconcile, you compare two amounts: the premium tax credit you used in advance during the year; and the amount of tax credit you qualify for based on your final income. You’ll use IRS Form 8962 to do this. If you used more premium tax credit than you qualify for, you’ll pay the difference with your federal taxes. If you used less, you’ll get the difference as a credit.

Referral
A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don’t get a referral first, the plan may not pay for the services.

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/or outpatient settings.

Service Area
A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may end your coverage if you move out of the plan's service area.

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Silver Health Plan
One of 4 categories of Health Insurance Marketplace plans (sometimes called "metal levels"). Silver plans fall about in the middle: You pay moderate monthly premiums and moderate costs when you need care.
Important: If you qualify for "cost sharing reductions" (or "extra savings") you can save a lot of money on deductibles, copayments, and coinsurance when you get care — but only if you pick a Silver plan**.** Silver plans are the most common choice of Marketplace shoppers.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Skilled Nursing Facility Care
Skilled nursing care and rehabilitation services provided on a continuous, daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period (SEP)
A time outside the yearly Open Enrollment Period when you can sign up for health insurance. You qualify for a Special Enrollment Period if you've had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child.

If you qualify for an SEP, you usually have up to 60 days following the event to enroll in a plan. If you miss that window, you have to wait until the next Open Enrollment Period to apply.

You can enroll in Medicaid and the Children's Health Insurance Plan (CHIP) any time of year, whether you qualify for a Special Enrollment Period or not.

Job-based plans must provide a special enrollment period of at least 30 days.

Specialist
A physician specialist focuses 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 more training in a specific area of health care.

Stand-alone dental plan
A type of dental plan offered through the Marketplace that's not included as part of a health plan. You may want this if the health coverage you choose doesn't include dental, or if you want different dental coverage.

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Subsidized Coverage
Health coverage available at reduced or no cost for people with incomes below certain levels. Examples of subsidized coverage include Medicaid and the Children's Health Insurance Program (CHIP). Marketplace insurance plans with premium tax credits are sometimes known as subsidized coverage too.

- In states that have expanded Medicaid coverage, your household income must be below 138% of the federal poverty level to qualify.
- In all states, your household income must be between 100% and 400% of the federal poverty level to qualify for a premium tax credit that can lower your insurance costs.

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 the "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.

Supplemental Security Income (SSI)
A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or 65 or older. SSI benefits aren't the same as Social Security retirement or disability benefits.

TRICARE
A health care program for active-duty and retired uniformed services members and their families.

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 and/or dependents.

Tax Filing Requirement
The minimum amount (or threshold) of income requiring you to file a federal tax return. 2018 filing requirements for most taxpayers**:** Gross income of at least $12,000 (individuals) or $24,000 (married filing jointly). Different thresholds apply for dependents, people 65 and older, and those who use other tax filing statuses (like married filing separately).

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

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

Vision Coverage
A health benefit that at least partially covers vision care, like eye exams and glasses. All plans in the Health Insurance Marketplace include vision coverage for children. Only some plans include vision coverage for adults.

If adult vision coverage is important to you, check the details of any plan you're considering. If your plan doesn't include adult vision coverage, you can buy a "stand-alone" vision plan to reduce your vision care expenses.

The Marketplace doesn't offer stand-alone vision plans. To shop for stand-alone vision plans, contact an insurance agent or broker, or search for plans online. You can also contact your state's Department of Insurance.

Waiting Period (Job-based coverage) - A waiting period is the period of time between when an action is requested or mandated and when it occurs. Used for new health insurance policies where incidents which occur during this time are not claimable.