



The Marketplace

Terminology

Actuarial Value- the average share of total health spending on essential benefits paid for by the plan. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits.

Annual Open Enrollment Period- A specific set of dates when a consumer can go onto the Marketplace and can pick their healthcare plan.

Assessed Eligible- An initial decision that consumers are possibly entitled for Medicaid or CHIP, the Marketplace will forward the data to the Medicaid/CHIP office for a **final** decision.

Children's Health Insurance Program (CHIP) - A state and federal government program that offers health coverage to low income children that do not meet the guidelines for Medicaid.

Claim- A request for payment that a consumer or healthcare provider sends in to the health insurance company for services or equipment they think are owed.

Coinsurance- Your share of the fees of a covered health care service, calculated as a percent of the allowed amount for the service. For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.

Copayment- An exact amount of cash you pay for a covered health care service, this is usually paid the day you go to the doctor or get medicine.

Consumer- Defined as individuals, families, small business owners, and employees who may get health coverage through the marketplace.

Deductible- The amount of money that you pay for your healthcare before the insurance begins to pay. (Deductibles do not apply to all services.)

Determined Eligible- the Marketplace makes a final decision of consumers' eligibility for Medicaid or CHIP; the Marketplace will send the determination information to the state Medicaid/CHIP agency for enrollment coverage.

Essential Health Benefits- Requires plans inside and outside of the exchanges to offer a basic set of benefits that include:

- Ambulatory Services
- Emergency Services
- Hospitalization
- Maternity
- Mental Health / Substance Abuse
- Prescription Drugs
- Rehabilitative Services
- Lab Services
- Preventative Care
- Pediatric Services



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Formulary- A list of medications that the insurance company will cover, includes details about the copayment that the consumer pays for each type of covered drug, the drugs are listed by levels.

Health Care Sharing Ministry- A non-profit group where the members have the same ideas and beliefs and they pay for each member's health care costs.

Health Insurance- A contract between a consumer and a health insurance company that requires the insurance company to pay or reimburse some or all of a consumer's healthcare cost when he or she gets sick or needs medical care. A consumer is required to pay a fixed monthly amount as a part of the contract.

Hub- Pulls information electronically from agencies, such as the IRS, SSA, and the Department of Homeland Security, about consumers so they don't have to collect all the needed information to verify identity, income and other factors to help decide eligibility for coverage. The Hub is set up to help keep consumers from getting denials of coverage based on their inability to find important papers, such as a birth certificate. Data being shared with or received from the Hub is protected and isn't shared for any other reasons.

Indemnity Plans- Also known as Fee for Service- Least restrictive of all plans allows consumers to pick their own doctors and repay provider for a part of the total cost for each service used by consumers.

Individual Responsibility Requirement- Consumers must keep minimum basic health coverage or pay a fee.

Premium- The amount of money that a consumer must pay to an insurance company for a health plan.

Provider Network- A contract among specific hospitals, doctors, pharmacies, and other health care providers to give medical care for an agreed payment.

Medicaid- A joint federal and state managed health insurance plan for low income families, children, pregnant women, elderly, and people with disabilities.

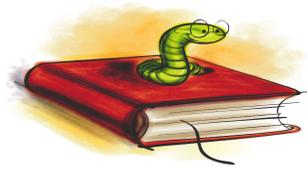
Medicare- A federal health insurance plan for people 65 years or older, some young people with disabilities, and people with end stage renal failure.

Out-of-pocket maximum- The most you pay during a policy period before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, or health care your health insurance or plan doesn't cover. Some health insurance plans don't count your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

OHP- Qualified Health Plan- Health plans that are certified by the Health Insurance Marketplace that offers essential health benefits, follows established limits on deductibles, copayments, out of pocket maximums, and meets other requirements

Special Enrollment Period - A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage. **Job-based plans** must offer a special enrollment period of 30 days following specific life events that involve a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage.

Tricare- A Department of Defense healthcare program offered to eligible members and their families of the military.



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Veterans Affairs Health Benefits- the Veterans Affairs offers health coverage for entitled veterans who serve in the United States Military.

Personally Identifiable Information (PII) - information that can identify a person.

Premium tax credits- a new tax credit to help you pay for health coverage bought through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Presumptive Eligibility - temporary approval of Medicaid benefits based on a review of gross family income before having a formal eligibility decision.