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MOST IMPORTANT TERMS:

- **Deductible**: How much you have to spend for covered health services before your insurance company pays anything (except free preventive services)
- **Copayments and coinsurance**: Payments you make each time you get a medical service after reaching your deductible
- **Out-of-pocket maximum**: The most you have to spend for covered services in a year. After you reach this amount, the insurance company pays 100% for covered services.

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.

- Many plans pay for certain services, like a checkup or disease management programs, before you've met your deductible. Check your plan details.
- All Marketplace health plans pay the full cost of certain preventive benefits even before you meet your deductible.
- Some plans have separate deductibles for certain services, like prescription drugs.
- Family plans often have both an individual deductible, which applies to each person, and a family deductible, which applies to all family members.

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

Copayment

A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible.

Let's say your health insurance plan's allowable cost (Allowed Amount is the maximum amount a plan will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate”).

If your provider charges more than the plan’s allowed amount, you may have to pay the difference

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.

Copayments (sometimes called "copays") can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

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

Coinsurance

The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Let's say your health insurance plan's allowed amount for an office visit is $100 and your coinsurance is 20%.

- If you've paid your deductible: You pay 20% of $100, or $20. The insurance company pays the rest.
- If you haven't met your deductible: You pay the full allowed amount, $100.

Example of coinsurance with high medical costs

Let's say the following amounts apply to your plan and you need a lot of treatment for a serious condition. Allowable costs are $12,000.

- Deductible: $3,000
- Coinsurance: 20%
- Out-of-pocket maximum: $6,850

You'd pay all of the first $3,000 (your deductible).

You'll pay 20% of the remaining $9,000, or $1,800 (your coinsurance).

So your total out-of-pocket costs would be $4,800 — your $3,000 deductible plus your $1,800 coinsurance.

If your total out-of-pocket costs reach $6,850, you'd pay only that amount, including your deductible and coinsurance. The insurance company would pay for all covered services for the rest of your plan year.

Generally speaking, plans with low monthly premiums have higher coinsurance, and plans with higher monthly premiums have lower coinsurance.

Out-of-pocket maximum/limit

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 2017 plan year:** The out-of-pocket limit for a Marketplace plan is **$7,150** for an individual plan and **$14,300** for a family plan.
- **For the 2016 plan year:** The out-of-pocket limit for a 2016 Marketplace plan is **$6,850** for an individual plan and **$13,700** for a family plan.

Example of out-of-pocket maximum with high medical costs

Let's say you need surgery with allowable costs of $20,000, and the following figures apply to your health insurance plan.

- Deductible: $1,300
- Coinsurance: 20%
- Out-of-pocket maximum: $4,400

You pay the first $1,300 of covered medical expenses (your deductible).

Your 20% coinsurance on the rest of the costs ($18,700) comes to $3,740.

So your total costs would be $5,040. That's $1,300 (your deductible) plus $3,740 (coinsurance).

But your out-of-pocket maximum is $4,400. Your insurance company pays all covered costs above $4,400 — for this surgery and any covered care you get for the rest of the plan year.

Generally, plans with lower monthly premiums have higher out-of-pocket limits. Plans with higher premiums usually have lower out-of-pocket maximums.

MORE IMPORTANT TERMS:

Affordable Care Act (ACA)

The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or “Obamacare”).

The law has 3 primary goals:

- Make affordable health insurance available to more people. The law provides consumers with subsidies (“premium tax credits”) that lower costs for households with incomes between 100% and 400% of the federal poverty level.
- Expand the Medicaid program to cover all adults with income below 138% of the federal poverty level. (Not all states have expanded their Medicaid programs.)
- Support innovative medical care delivery methods designed to lower the costs of health care generally

Bronze Health Plan

One of 4 plan categories (also known as “metal levels”) in the Health Insurance Marketplace. Bronze plans usually have the lowest monthly premiums but the highest costs when you get care. They can be a good choice if you usually use few medical services and mostly want protection from very high costs if you get seriously sick or injured.

Note: Bronze plan deductibles can be very high. This means you could have to pay thousands of dollars of health care costs yourself before your plan starts to pay its share.

All health plans in all categories provide free preventive services, and some plans offer other services at low or no cost before you meet your deductible.

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.

Children's Health Insurance Program (CHIP)

Insurance program that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid but not enough to buy private insurance. In some states, CHIP covers pregnant women.

Each state offers CHIP coverage and works closely with its state Medicaid program. You can apply any time. If you qualify, your coverage can begin immediately, any time of year.

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. For more information, visit cms.gov.

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.

Dependent

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

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.

Exclusive Provider Organization (EPO) Plan

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).

Employer Shared Responsibility Payment (ESRP)

The Affordable Care Act requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to its full-time employees (and their dependents) that meets certain minimum standards set by the Affordable Care Act or to make a tax payment called the ESRP.

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.

Exemption

Most people must have qualifying health insurance or pay a fee. But people who qualify for a health coverage exemption don't have to pay the fee. Exemptions are granted based on certain hardships and life events, health coverage or financial status, membership in some groups, and other circumstances.

Federal Poverty Level (FPL)

A measure of income issued every year by the Department of Health and Human Services. 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.

The 2016 federal poverty level (FPL) income numbers below are used to calculate eligibility for Medicaid and the Children's Health Insurance Program (CHIP). 2015 numbers are slightly lower, and are used to calculate savings on Marketplace insurance plans for 2016.

- $11,880 for individuals
- $16,020 for a family of 2
- $20,160 for a family of 3
- $24,300 for a family of 4
- $28,440 for a family of 5
- $32,580 for a family of 6
- $36,730 for a family of 7
- $40,890 for a family of 8

Flexible Spending Account (FSA)

An arrangement you set up through your employer to pay for many of your out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles, and qualified prescription drugs, insulin and medical devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. You don't have to pay taxes on this money. Your employer's plan sets a limit on the amount you can put into an FSA each year.

There is no carry-over of FSA funds. This means that FSA funds you don't spend by the end of the plan year can't be used for expenses in the next year. An exception is if your employer's FSA plan permits you to use unused FSA funds for expenses incurred during a grace period of up to 2.5 months after the end of the FSA plan year.

(Note: Flexible Spending Accounts are sometimes called Flexible Spending Arrangements.)

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.

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.

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.

When you apply for individual and family coverage through the Marketplace, you'll provide income and household information. You'll find out if you qualify for:

- Premium tax credits and other savings that make insurance more affordable
- Coverage through the Medicaid and Children's Health Insurance Program (CHIP) in your state

On HealthCare.gov, you may be asked to select your state or enter your ZIP code. If you live in a state that runs its own Marketplace, we'll send you to your state's Marketplace website.

Health Savings Account (HSA)

A type of savings account that allows you to set aside money on a pre-tax basis to pay for qualified medical expenses if you have a "high deductible" health insurance plan.

Combining a High Deductible Health Plan with a Health Savings Account (HSA) allows you to pay for certain medical expenses, like your deductible and copayments, with untaxed dollars. High-deductible plans usually have lower monthly premiums than plans with lower deductibles.

Unlike a Flexible Spending Account (FSA), HSA funds roll over year to year if you don't spend them. You can take the funds with you if you change jobs or leave the work force. Your HSA may also earn interest.

You can start an HSA through your own bank or other financial institution.

Health Plan Categories

Levels of plans in the Health Insurance Marketplace: Bronze, Silver, Gold, and Platinum. Categories (sometimes called "metal levels") are based on how you and your insurance plan split costs. Categories have nothing to do with quality of care. ("Catastrophic" plans are available to some people.)

For each plan category, you'll pay a different percentage of total yearly costs of your care, and your insurance company will pay the rest. Total costs include premiums, deductibles, and out-of-pocket costs like copayments and coinsurance.

Each category may include several types of plans and provider networks, like health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

In-network 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.

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.

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"). On the web, it's found at HealthCare.gov. Some states run their own Marketplaces at different websites.

- Fill out a Marketplace application and you'll find out if you qualify for lower monthly premiums or savings on out-of-pocket costs based on your income.
- You may find out if you qualify for Medicaid or the Children's Health Insurance Program (CHIP).

You can shop for and enroll in affordable medical insurance online, by phone, or with in-person help from a trained assister or an agent or broker.

There's a separate Marketplace — called the Small Business Health Options Program (SHOP) Marketplace — where small businesses with fewer than 50 employees can shop for and buy medical insurance for their employees.

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 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.

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.

Medicare

A federal health insurance program for people 65 and 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).

Medicare isn’t part of the Health Insurance Marketplace. If you have Medicare coverage you don’t have to make any changes. You’re considered covered under the health care law.

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.

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 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.

Network

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

Obamacare

An informal name sometimes used to refer to the health coverage plans available through the Health Insurance Marketplace. Obamacare often also refers to the Affordable Care Act.

Obamacare Summary:

- Signed into law March 23, 2010 by President Obama, which is where the term "Obamacare" comes from
- The Open Enrollment Period for 2017 insurance started November 1, 2016 and ends January 31, 2017
- The Health Insurance Marketplace helps you find and enroll in a plan

Out-of-Network Coinsurance

The percentage (for example, 40%) you pay of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Open Enrollment Period

The yearly period when people can enroll in a health insurance plan. Open Enrollment for 2017 runs from November 1, 2016 to January 31, 2017.

Outside the Open Enrollment Period, you generally can enroll in a health insurance plan only 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.

Original Medicare

Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Out-of-Pocket Costs

Your 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.

Pre-Existing Condition Exclusion Period (Individual Policy)

The time period during which an individual policy won't pay for care relating to a pre-existing condition. Under an individual policy, conditions may be excluded permanently (known as an "exclusionary rider"). Rules on pre-existing condition exclusion periods in individual policies vary widely by state.

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.

Penalty

A payment (“fee,” “fine,” “individual mandate”) you make if you don’t have health insurance that counts as qualifying health coverage. The penalty in 2016 and 2017 for not having health coverage is $695 for each person on your tax return who isn’t covered ($347.50 per child), or 2.5% of your household income, whichever is more.

- You owe a fee for any month you, your spouse, or your tax dependents don’t have qualifying health coverage.
- You’ll pay the fee when you file your federal income tax return.

If you’re uncovered just some months of the year, you pay 1/12 of the penalty for each month you’re uninsured. If you’re uncovered for only 1 or 2 consecutive months, you don’t have to pay the fee at all.

People with very low incomes and others with special circumstances may be eligible for exemptions from the requirement to have health insurance. If you qualify for an exemption, you won’t have to pay the fee.

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.

Pre-Existing Condition

A health problem you had before the date that new health coverage starts.

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.

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.

Qualified Health Plan

An insurance plan that's certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act. All qualified health plans meet the Affordable Care Act requirement for having health coverage, known as "minimum essential coverage."

Qualifying Health Coverage

Any health insurance that meets the Affordable Care Act requirement for coverage. If you have qualifying health coverage (or "minimum essential coverage" or "MEC") you don't have to pay the penalty for being uninsured. Examples: individual plans, including Marketplace plans; job-based plans; Medicare; and Medicaid & CHIP.

A more complete list of qualifying health coverage:

- Job-based plans
- Health Insurance Marketplace plans
- Most individual plans bought outside the Marketplace
- Medicare
- Medicaid
- The Children's Health Insurance Program (CHIP)
- TRICARE

- COBRA
- Plans sold through the Small Business Health Insurance Program (SHOP) Marketplace

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

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.

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.

Social Security Benefits

The amount you get from Social Security Disability, Retirement (including Railroad retirement), or Survivor's Benefits each month.

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.

Self-Employment Income

The net income you earn from your own trade or business. For example, any net income (profit) you earn from goods you sell or services you provide to others counts as self-employment income.

Self-employment income could also come from a distributive share from a partnership.

TRICARE

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

Tax filing requirement (for dependents)

You must include on your Marketplace application income for any dependent required under IRS rules to file a federal tax return. Generally, unmarried dependents under 65 must file if they have **earned** income over $6,300 or **self-employment** income over $400 (for 2015, the most recent year available). Different filing requirements apply for dependents with unearned income (like from investments or trusts) or who are married, 65 or older, or blind.

- Earned income includes: salaries, wages, tips, and **taxable** scholarships and fellowships

- Unearned income includes: interest or dividends from investments, distributions from trusts, unemployment compensation, and taxable Social Security benefits

Note: If a dependent isn't required to file a tax return but does anyway — like to get a refund — you don't have to count their income on your Marketplace application.

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)

The time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible for coverage under a job-based health plan.

Worker's Compensation

An insurance plan that employers are required to have to cover employees who get sick or injured on the job.

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.

Wellness Programs

A program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings.

Zero cost sharing plan

A plan available to members of federally recognized tribes and Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders whose income is between 100% and 300% of the federal poverty level and qualify for premium tax credits. People enrolled in this type of plan:

- Don't pay co-payments, deductibles, or coinsurance when getting care from an Indian health care provider or when getting essential health benefits through a Marketplace plan
- Don't need a referral from an Indian health care provider when getting essential health benefits through a Marketplace plan
- Can get zero costs sharing with a plan at any metal level on the Marketplace
- Must agree to have their income verified in order to enroll

"If we LEARN together, we will EARN together!"

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