Glossary

Virginia's Insurance Marketplace

Adjusted Gross Income: Your total (or "gross") income for the tax year, minus certain adjustments you're allowed to make. Adjusted gross income appears on IRS Form 1040, line 11.

Advance Premium Tax Credit (APTC): The federal government offers this tax credit to help pay for private health insurance for individuals and families within certain income limits who also meet other requirements. The tax credit can be automatically applied toward your insurance premiums to lower your monthly payment, or you can claim it when you file your federal tax return. You must apply for financial assistance to confirm eligibility and to receive the tax credit.

Affordable Care Act: The federal health law that requires most Americans to have health insurance that provides Minimum Essential Coverage. The name refers to two pieces of legislation: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

Agent: Agents are licensed under Virginia law to sell health insurance to individuals, families, and small businesses and their employees. Agents can recommend plans or plan types and perform activities on behalf of their clients. Only agents who have been trained and certified by Virginia's Insurance Marketplace are authorized to assist you in using the Marketplace. There is no cost to use an agent.

American Indian and Alaska Native: A member of a federally recognized tribe or Alaska Native tribe, band, nation, pueblo, village, or community that the U.S. Department of the Interior acknowledges as an Indian tribe, including Alaska Native Claims Settlement Act regional village corporations.

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.

Assister: Another term for a Virginia's Insurance Marketplace assister.

Authorized Representative: Someone you choose to act on your behalf. The person could be a family member, an agent, a person you trust, or someone who has legal authority to act on your behalf.

Bronze Health Plan: Health plans in the Bronze Metal Level pay about 60% of in-network expenses for an average population of consumers. The Premiums are typically among the lowest, but the Deductible and Out-of-Pocket Limit are among the highest. Metal levels only focus on what the plan is expected to pay and do NOT reflect the quality of health care or service providers available through the health insurance plan. Once you meet your in-network out-of-pocket limit for the plan year, plans pay 100% of the allowed amount for covered services.

Catastrophic Plan: A health plan with a low monthly Premium and a high annual Deductible designed to protect you from worst-case situations like a serious illness or accident. Catastrophic plans are only available to people under age 30 or people with a hardship exemption. Catastrophic plans provide Essential Health Benefits and count as having insurance coverage for tax purposes. Plans cover at least three primary care visits during the plan year and certain preventive services at no cost. You pay all other medical costs until the annual deductible is met. Then the plan pays 100% for covered services for the rest of the plan year. Advance Premium Tax Credits and Cost-Sharing Reductions can't be used with this plan type.

Centers for Medicare and Medicaid Services: The federal agency that runs Medicare, Medicaid, the Children's Health Insurance Program, and the federal health insurance marketplace.

Coinsurance: The percentage you pay of the total cost for a covered service, which you pay at the time you receive the service. For example, if your health insurance plan's allowed amount to visit your doctor is $100, a coinsurance payment of 20% would be $20. Some plans require that you pay up to the plan's Deductible amount before coinsurance begins. Once you reach your Out-of-Pocket Limit, you no longer have to pay coinsurance for the rest of the plan year.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): A federal law that may allow you to keep employer-sponsored health insurance if you lose your job. In most cases, you pay the full costs every month plus a small administrative fee if you choose to keep the coverage you received under your former employer. COBRA coverage is typically available up to 18 months (or longer, but only in special circumstances). If you live in Virginia and leave your job for any reason, you have 60 days from the date you lose coverage to either enroll in COBRA (if eligible) or sign up for a private plan through the Marketplace. However, if you enroll in a COBRA plan and then voluntarily drop it or stop paying the Premiums, you can't enroll in a private plan through the Marketplace until the next annual Open Enrollment Period.

Copayment: A fixed dollar amount you pay for a covered service, usually at the time you receive the service. The amount can vary depending on the type of service. For example, your copayment for a doctor visit may be $25 while your copayment for prescription drugs is $10. Once you reach your Out-of-Pocket Limit, you no longer have to pay copayments for the rest of the plan year.

Cost-Sharing Reduction (CSR): A discount that lowers your costs for Deductibles, Coinsurance, and Copayments and that also lowers what you must pay to reach your Out-of-Pocket Limit. To get these savings, you must apply for Financial Assistance. During the application process, Virginia's Insurance Marketplace will help you determine whether you qualify. Then you can enroll. You must enroll in a Silver Health Plan to receive CSRs. American Indians and Alaska Natives receive additional CSRs regardless of a plan's Metal Level.

Coverage: Another word for health insurance. You can obtain coverage through the Marketplace, an employer, or a program like Medicare.

Covered Services: The health care services you're entitled to receive based on the terms of your health insurance plan. All plans available through the Marketplace cover Essential Health Benefits. Other covered services or excluded services vary among plans. Each plan available through the Marketplace includes a summary of benefits and coverage — but it's only a summary. The plan documents contain all the benefits information.

Deductible: The amount you must pay during the plan year for Covered Services before your insurance company begins to contribute toward costs. For example, if your annual in-network deductible is $1,000, your health insurance company may not pay anything for covered services until you reach this amount. The deductible may not apply to all services. For example, most plans include certain preventive services at no cost even before you meet your deductible. Some plans also have separate deductibles for specific benefits like prescription drugs.

Dependent (also referred to as a "tax dependent"): A person (other than you or your spouse) such as a child, parent, or other relative for whom you're entitled to claim a personal exemption on your federal tax return. The IRS has a tool to help determine who you can claim as a dependent.

Effectuation Date: This is the date that your health coverage starts. Typically, this happens after the first payment (sometimes called a "binder payment") is made.

Enrollee: A person enrolled in a Qualified Health Plan or off-Marketplace plan.

Essential Health Benefits: All health insurance plans available through Virginia's Insurance Marketplace are required by federal law to include essential health benefits. These benefits include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitation services and habilitative services and devices; laboratory services; preventive services and chronic disease management; and pediatric services, including dental and vision care for children. This doesn't mean that all plans are the same. Some plans may offer a higher level of service or additional services beyond the minimum required or exclude other optional services that may be important to you.

Exchange: Another term for a Health Insurance Marketplace.

Family Access to Medical Insurance Security Plan: Virginia's health insurance program for children. The program covers checkups, dental care, doctor visits, emergency care, hospital visits, mental health care, prescription medicine, tests and X-rays, vaccinations, and vision care.

Federal Poverty Level: A measure of income used to determine eligibility for certain financial assistance programs. The guidelines are issued each year by the U.S. Department of Health and Human Services.

Federally Qualified Health Center: Nonprofit health centers or clinics that receive federal funding to serve medically underserved areas and populations. The centers provide low-cost and no-cost primary care services on a sliding scale fee, based on your ability to pay.

Federally Recognized Tribe: An American Indian or Alaska Native tribal entity that is recognized as having a government-to-government relationship with the United States. Tribe members are eligible for enhanced savings, benefits, and protections through Virginia's Insurance Marketplace when they apply for financial assistance.

Financial Assistance: An umbrella term used by the Marketplace to describe Medicaid and federal programs that help you pay for private health insurance. Advance Premium Tax Credits and Cost-Sharing Reductions are types of financial assistance.

Gold Health Plan: Health plans in the Gold Metal Level pay 80% of in-network expenses for an average population of consumers. The Premiums are typically higher, but the Deductible and Out-of-Pocket Limit are lower. Metal levels only focus on what the plan is expected to pay and do NOT reflect the quality of health care or service providers available through the health insurance plan. Once you meet your in-network out-of-pocket limit for the plan year, plans pay 100% of the allowed amount for covered services.

Group Health Plan: An umbrella term generally used to describe a health plan offered by either an employer or an employee organization (such as a union) that provides medical coverage to plan participants.

Hardship Exemption: An exemption that's needed when applying for a Catastrophic Plan for people age 30 and older who faced a hardship that prevented them from getting insurance. Hardship exemptions are filed through HealthCare.gov, not Virginia's Insurance Marketplace. Learn about hardship exemptions and catastrophic plans.

Health Insurance Marketplace: A state-based or federally facilitated marketplace where individuals, families, and small businesses and their employees can get quality, affordable health insurance.

Health Insurance Portability and Accountability Act (HIPAA): A federal law that sets rules about who can see, use, or share your health information and provides other protections to consumers. HIPAA gives you rights over your health information and requires doctors, pharmacists, other health care providers, and your health plan to explain your rights. The law has specific privacy and security requirements to safeguard your electronic health information and to notify you if there's ever a security breach.

Health Maintenance Organization: A type of health plan that usually only covers care from In-Network service providers. It generally won't cover Out-of-Network care except in an emergency and may require you to live or work in its service area to be eligible for coverage. You may be required to choose a primary care physician.

Health Reimbursement Arrangement: An optional benefit, funded by the employer, that reimburses plan participants for qualified medical expenses up to a fixed amount. The reimbursements are tax-free, and any unused funds can be rolled over for use in future years.

Health Savings Account: A bank account in which you deposit pre-tax dollars to pay for qualified medical expenses such as your Deductible, Copayments, and Coinsurance. If you have a High-Deductible Health Plan, you may be eligible for a health savings account. The IRS sets an annual limit on contributions, but any funds you deposit can be used in future years. If you have a health savings account through your employer, the funds belong to you and can roll over into another qualifying account if you ever leave.

High-Deductible Health Plan: A plan that has a higher annual Deductible and lower monthly Premiums. You pay more for health care upfront, before your insurance company starts to pay. With a high-deductible health plan, you're eligible to open a tax-deductible Health Savings Account. The IRS defines the limits for plans that qualify as high-deductible health plans, and the deductible and Out-of-Pocket Limit may be adjusted annually for inflation.

In-Network: Refers to the network of service providers and suppliers your health insurance company has contracted with to provide health care services. Some health insurance plans only let you use in-network providers (sometimes called "preferred service providers") and only cover Out-of-Network providers on a limited basis. It costs less to use in-network service providers.

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Life Change: Also called a Qualifying Life Event. Certain life changes make you eligible to enroll in health insurance coverage or make changes to your plan during a Special Enrollment Period, which occurs outside of the annual Open Enrollment Period.

Medicaid: Medicaid is a joint federal-state health program that provides health care coverage to low-income and disabled adults, children, and families. Medicaid in Virginia is referred to as Virginia Medicaid. To be eligible, you must be a Virginia resident and must meet nonfinancial and financial eligibility requirements. Virginia Medicaid covers many services, including doctor visits, hospital care, prescription drugs, mental health services, transportation, and many other services at little or no cost to you.

Medicare: A federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant). The program helps with the cost of health care, but it doesn't cover all medical expenses or the cost of most long-term care. The program is administered through the Social Security Administration, not through Virginia's Insurance Marketplace. Learn more about when and how to apply for Medicare.

Metal Levels: Plans on Virginia's Insurance Marketplace are assigned metal levels to indicate how generous they are in paying expenses. Metal levels only focus on what the plan is expected to pay and do NOT reflect the quality of health care or service providers available through the health insurance plan. Bronze Health Plans pay 60% of medical expenses for the average population of consumers, Silver Health Plans pay 70%, Gold Health Plans pay 80%, and Platinum Health Plans pay 90%. Bronze and Silver plans generally have lower Premiums, but you pay more at the time you receive covered services. Gold and Platinum plans generally have higher premiums, but you pay less at the time you receive covered services.

Minimum Essential Coverage: Health coverage that meets the requirements of the Affordable Care Act. All private health plans available through the Marketplace meet or exceed this standard. Virginia Medicaid and Medicare also provide minimum essential coverage. For medical coverage outside of the Marketplace or through another government program, find out what kind of health coverage qualifies as minimum essential coverage.

Minimum Value: A standard applied to employer-sponsored health insurance. A plan meets the minimum value if it pays at least 60% of the total cost of medical services for a standard population of consumers and offers substantial coverage for hospital and doctor services. If your employer's plan meets this standard and is considered affordable, and you choose to buy private insurance through Virginia's Insurance Marketplace, you won't be eligible for an Advance Premium Tax Credit.

Modified Adjusted Gross Income: The income calculation that determines whether you qualify for Virginia Medicaid or an Advance Premium Tax Credit. Modified adjusted gross income is your household's Adjusted Gross Income (as calculated when you file your taxes) plus any nontaxable Social Security benefits, tax-exempt interest, and foreign income.

Network: The doctors, specialists, other service providers, facilities, and suppliers that a health insurance company contracts with to provide health care services to plan members.

Notice: A message informing you about important information related to your health insurance. You may receive a notice in the mail or as an alert by email. Notices are time sensitive and may affect your health insurance.

Open Enrollment Period: A limited time period every year when anyone can enroll in a health insurance plan, typically from November 1 through January 15. If your employer offers health insurance, the Open Enrollment Period will be shorter and at a different time. You can apply for and enroll in Virginia Medicaid anytime.

Out-of-Network: Refers to a doctor or facility that has no contract with your health insurance company. Some health insurance plans only let you use In-Network providers and only cover out-of-network providers on a limited basis. It costs less to use in-network service providers.

Out-of-Pocket Costs: Expenses you incur for medical services that your insurance company doesn't pay for, including Deductibles, Copayments, and Coinsurance. These costs include any you incur for excluded services.

Out-of-Pocket Limit: The maximum you must pay for Covered Services in a plan year before your health insurance company pays 100%. After you spend the out-of-pocket limit amount on Deductibles, Copayments, and Coinsurance, your health insurance pays 100% of the allowed amount for covered services. Premiums don't count toward your out-of-pocket limit.

Plan Year: A 12-month period during which the benefits and premium rates for insurance plans stay the same. The plan year for individual and family plans is the same as the calendar year, even if you're not enrolled for the whole calendar year. If you're enrolled in a group health plan through an employer, your plan year may not be the same as the calendar year.

Platinum Health Plan: Health plans in the Platinum Metal Level pay 90% of in-network expenses for an average population of consumers. The Premiums are typically among the highest, but the Out-of-Pocket Limit is usually the lowest. The plan may not have a Deductible at all. Metal levels only focus on what the plan is expected to pay and do NOT reflect the quality of health care or service providers available through the health insurance plan. Once you meet your in-network out-of-pocket limit for the plan year, plans pay 100% of the allowed amount for covered services.

Preferred Provider Organization: A plan type that covers care from both In-Network and Out-of-Network providers. You pay less if you use in-network providers. You can use out-of-network providers for an additional cost.

Premium: The amount you pay for your health insurance every month.

Qualified Health Plan: A plan purchased through a Health Insurance Marketplace, such as the private plans available through Virginia's Insurance Marketplace.

Qualifying Life Event: If you experience a Life Change — including, but not limited to, getting married, having a baby, or losing your employer-sponsored insurance — you may be eligible to enroll in health insurance coverage or make changes to your plan during a Special Enrollment Period, which occurs outside of the annual Open Enrollment Period.

Remote Identity Proofing: The process of verifying your identity. This may be completed based on answers about your credit history, demographics, or other information. If this cannot be done electronically or over the phone with Experian, a credit reporting company, you may need to provide documentation to establish identity. This is a required step in applying for coverage.

Second Lowest Cost Silver Plan: The second-lowest-cost Silver Health Plan available to you through the Marketplace. Even if this isn't the plan in which you enroll, the premium you would be charged for this plan is used to calculate the amount of any Advance Premium Tax Credit you could be eligible to receive. Following enrollment, this amount is reported on IRS Form 1095-A.

Silver Health Plan: Health plans in the Silver Metal Level pay 70% of in-network expenses for an average population of consumers. The Premiums are typically lower, but the Out-of-Pocket Limit is higher. If you enroll in a Silver plan and qualify for a Cost-Sharing Reduction, you will have very low Out-of-Pocket Costs. Metal levels only focus on what the plan is expected to pay and do NOT reflect the quality of health care or service providers available through the health insurance plan. Once you meet your in-network out-of-pocket limit for the plan year, plans pay 100% of the allowed amount for covered services.

Social Security Administration: The federal agency that assigns Social Security numbers; administers the retirement, survivors, and disability insurance programs known as Social Security; and administers the Supplemental Security Income program for for older Americans and people with disabilities.

Special Enrollment Period: An enrollment period that takes place outside of the Open Enrollment Period and requires a Qualifying Life Event for eligibility. During a Special Enrollment Period, you can enroll in a new health plan or make changes to your existing plan.

Stand-Alone Dental Plan: A dental insurance plan that is not part of your health plan. Dental care for adults is typically not included in health plans.

Subsidy: An informal term for the Advance Premium Tax Credit or Cost-Sharing Reduction.

Teletypewriter (TTY): A telephone and text communications protocol for people with hearing loss or speech disabilities.

Virginia's Insurance Marketplace Assister: An individual who provdies in-person help to individuals, families, and small businesses shopping for health plans through Virginia's Insurance Marketplace. Assisters have been trained by the Marketplace and are required to provide fair and impartial information to help with eligibility and facilitate enrollment in health plans. There is no cost to use an assister.

Yearly Cost Estimate for Health Coverage: A feature of

the Virginia's Insurance Marketplace Plan Comparison Tool that shows the estimated amount you might pay in a given year for Premiums, Deductibles, Copayments, and Coinsurance. The estimate is based on the number of people covered, your health status, and any expected medical procedures.

Zero Cost-Sharing Plan: A plan that has no copayments, deductibles, or coinsurance for American Indian and Alaska Native consumers when care is received from Indian health care providers, which include health programs operated by the Indian Health Service, tribes and tribal organizations, and urban Indian organizations. Members of a Federally Recognized Tribe or corporation shareholders under the Alaska Native Claims Settlement Act whose income is at or below 300% of the federal poverty level are eligible for a zero cost-sharing plan. This is also true when receiving Essential Health Benefits through a plan from Virginia's Insurance Marketplace. You don't need a referral from an Indian health care provider to receive these benefits. Zero cost sharing is available for any Metal Level plan.