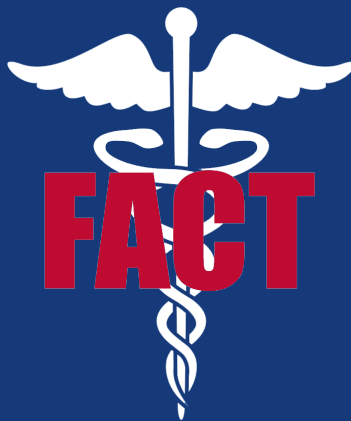


ObamaCarefacts.com Guide to Open Enrollment 2017

ObamaCareFacts.com



Introduction

Our 2017 ObamaCare guide covers everything you need to know for open enrollment 2017. Open enrollment starts Nov. 1, 2016 and ends Jan. 31, 2017. Whether you already have a health plan or not, this quick and simple guide will help you cover your bases during open enrollment.

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ADVICE: If you enrolled in a marketplace plan last year, be sure to verify your plan & information through the Health Insurance Marketplace by December 15. This will ensure you get the right coverage & cost assistance starting January 1st, 2017.



Get coverage & lower costs at the official Health Insurance Marketplace HealthCare.Gov

By reading this guide you'll learn:

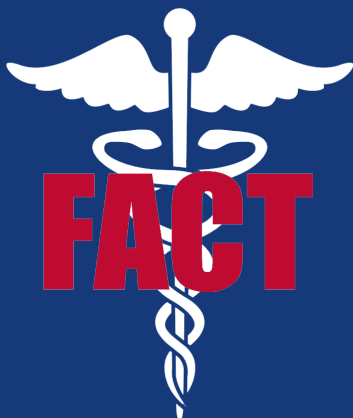
- About the fee for not obtaining health insurance and how to avoid it.
- How to understand and pick the right insurance option for you and your family.
- How to get the best deal on health insurance to save you money.
- How new 2017 changes to healthcare and health insurance under the ACA affect you.

We will cover:

- How to get a plan.
- How to switch plans.
- How to get cost assistance.
- Basic health insurance jargon & how to compare insurance plans.
- Your new benefits, rights & protections.
- Your options outside of the marketplace.
- Advice on using your insurance wisely.

What we won't cover:

- The details: The specifics of the law, the healthcare system, and their impact on America are vast. Often in this guide, we assume you know the ObamaCare basics. When you don't, please follow the links provided to learn more from our website ObamaCareFacts.com.



Grass roots Guide to ObamaCare

ObamaCareFacts.com is a grass roots, free, unbiased, fact-based, source of information about the Patient Protection Affordable Care Act.

On ObamaCareFacts.com we do our best to cover "ObamaCare" as a whole. For the purposes of this guide, we will just cover the need-to-knows to take advantage of the Affordable Care Act in 2016.

FACT: Nothing in this guide should be taken as legal advice or professional medical advice. We are writers, not doctors or lawyers!

So What is This ObamaCare Thing?

In case you didn't know, or needed a refresher, the Patient Protection Affordable Care Act (AKA ObamaCare, PPACA, or ACA, for short) is America's solution to health care & health insurance. The ACA is not the socialized medicine that the left-of-liberal-medicare-for-all folks wanted. It is also not the pay-to-play free-market-libertarian-road-warrior-esq system other folks wanted. For better or worse, the ACA is a center-of-center, uniquely American solution to health care.

The ACA compiles decades of ideas from the left, right, middle, academics, doctors, and corporations. It's goal is to expand the affordability, quality, and availability of private and public health insurance through consumer protections, regulations, subsidies, taxes, and insurance exchanges. The President may have advocated for health care reform under the ACA and personally signed the bill into law, but the law itself has little to do with President Obama beyond that.



The Patient Protection Affordable Care Act Isn't Just One Thing.

The PPACA isn't just one thing to be loved or hated. It is a collection of healthcare related provisions that stand alone as often as they interconnect. Below are the results of some of the most important provisions found in the 1,000-ish page law.



Its Lots of Little Things.

- **Health Insurance Marketplaces** allow shoppers to compare health plans which include all new benefits, rights & protections.
- **All American's, who can afford to, must obtain coverage**, get an exemption, or pay a fee.
- **Cost assistance** is provided to individuals & families through the marketplace if they make less than 400% of the federal poverty level (FPL).
- **Tax credits for small businesses** who employ less than 25 full-time equivalent (FTE) employees.
- **Medicaid eligibility expanded in 31 states** for all adults who make less than 138% FPL. For millions of Americans this provided access to healthcare insurance for the first time.
- **No annual or lifetime limits on essential healthcare coverage** protecting folks from the leading cause of bankruptcy: medical debt.
- **All major medical insurance is guaranteed to be issued**; meaning, if you can pay the premium, you can't be denied coverage for any reason, even a pre-existing condition.
- **Insurance companies can't drop you when you are sick** or for making a mistake during the application process.

- **Large Employers had to offer coverage** by 2016.
- Reforms to the healthcare industry designed to **cut wasteful spending**.
- You have the **right to quickly appeal any health insurance company's decision** about your medical coverage or the services you receive.
- You have the **right to get an easy-to-understand summary about a health plan's benefits & coverage**.
- **Young adults can stay on their parent's health insurance plan until the age of 26**.
- **Improvements to women's health services**.
- Better care & protections for seniors by **reducing Medicare fraud, overpayments, and closing the Part D donut hole**.
- Adding coverage for **free preventative services** with no out-of-pocket costs.
- **Essential health benefits**: Emergency care, hospitalization, prescription drugs, as well as, maternity & newborn care must be included on all non-grand fathered plans with no annual or lifetime dollar limits.
- **You can't be charged more for your insurance because of health status or gender**.

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FACT: The Affordable Care Act contains ten titles that span about 1000 pages, however, most of it's key provisions are in the first title. The first title is about 140 pages long, but these pages are mostly white space with only about 450 characters per page.

FACT: There has been over 50 attempts to repeal the Patient Protection Affordable Care Act. It is important to understand what the law really does, in order to understand whether you support a full repeal.

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We've only scratched the surface of what the Patient Protection and Affordable Care Act does. You can see our full summary of the provisions found within the Patient Protection and Affordable Care Act here: obamacarefacts.com/summary-of-provisions-patient-protection-and-affordable-care-act/

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Aside from all the new benefits, rights, and protections contained within the law's many provisions, there is also the oh-so-popular mandate to obtain health coverage! So, let's talk about that.

Mandate for Coverage



Image from: facebook.com/Healthcare.gov

By this point, you probably know about the Individual Mandate (the requirement to obtain and maintain health insurance) and the exemptions from the mandate. If you don't, we suggest you read the following article: obamacarefacts.com/obamacare-individual-mandate/

Let's do a quick refresher of the basics. Remember these are rule-of-thumb definitions, not expert legal advice. In some cases, you may need to go to the site for more specific details.

Minimum Essential Coverage: The type of health insurance coverage that protects you from the fee. It includes all major medical plans inside & outside of the marketplace, Medicare, Medicaid, employer coverage, & TRICARE. It doesn't include short term health insurance. If you have a short term plan you'll want to switch to a major medical plan during open enrollment 2017.

The Individual Mandate: If you can afford to buy health insurance, than you must obtain & maintain Minimum Essential Coverage for at least 9 of 12 months each year. If you don't, you'll owe a per month fee for every month you went without coverage on end of year Federal Income Taxes.

The Fee: In 2016, the fee was \$695 per person & \$347.50 per child or 2.5% of your income (whichever is greater), but it can't exceed a national average bronze plan premium. The 2017 per person & per child fees haven't been released yet.

The Federal Poverty Guidelines (Federal Poverty Levels or FPL): The chart you will use to figure out if you qualify for cost assistance or an exemption based on income. Cost assistance is offered to those making under 400% FPL.

Exemptions: In general, if you make less than \$11,880 a year as an individual or \$24,300 for a family of four, you are exempt (in Alaska and Hawaii the limit is higher). You're also exempt if the cheapest plan after assistance will cost more than 8.16% of your families income, or 8.16% of employee only income after employer contributions.

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FACT: You can't go to jail for not having Minimum Essential Coverage or not paying the fee. You will simply owe the fee and the IRS will withhold it from your tax refund in order to collect it.
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Facts About the Individual Mandate

- Everyone gets a 'coverage gap exemption' each year allowing for up to 3 consecutive months without coverage before owing the fee.
- The Fee is officially part of the PPACA's "Shared Responsibility Provision" and thus is called the "Shared Responsibility Fee."
- Even if you are exempt from the fee, you can still get cost assistance for health insurance coverage. Hardship exemptions qualify you to shop for Catastrophic plans.
- The maximum penalty can't exceed the national average yearly premium cost for a bronze plan.
- The fee is 1/12 of the total fee, per household member, each month they go without coverage, unless you apply & qualify for an exemption.
- According to the Congressional Budget Office, almost 90% of the 30 million plus Americans without insurance, did not owe the penalty for not having insurance in 2016 largely because of number of exemptions from the fee.

Open Enrollment 2017

Open enrollment is a really important concept. You can only sign up for health insurance during that insurance type's open enrollment period and each type has its own enrollment period. For those using the marketplaces, or shopping outside the marketplaces for private insurance, the enrollment period for 2017 is Nov. 1, 2016 - Jan. 31, 2017. For those who qualify for Medicaid, you can enroll at anytime, but if you choose to use the marketplace to apply, you have to do so during the Nov. 1 - Jan. 31 marketplace open enrollment period.

See enrollment periods for other insurance types on our website:

obamacarefacts.com/obamacare-open-enrollment/

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FACT: If you move, lose coverage during the year, or have another qualifying life event you may qualify for a special enrollment period outside of open enrollment and/or qualify for an exemption from paying the Shared Responsibility Fee.

FACT: Private insurers have adopted the marketplaces' open enrollment periods.

ADVICE: Don't miss open enrollment. From Medicare to the marketplace, missing open enrollment means extra paperwork, and potentially, paying the fee.

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The Sign Up Process for the Health Insurance Marketplace

1. Set up an account on your states' marketplace website or the federal one. First, you'll provide some basic information. Then, you'll choose a user name, password, and security questions, for added protection.

2. Fill out the online application. You'll provide information about you and your family like income, household size, current health coverage information, and more. This will help the Marketplace find coverage options that meet the medical needs of you and your family.

IMPORTANT: If your household files more than one tax return, call the Marketplace Call Center before you start an application.

1-800-318-2596 | TTY 1-855-889-4325

This is a very important. Please don't skip this step. Representatives can provide you direction to make sure your application is accurate & processed correctly. State run marketplaces may have their own call centers.

The next page provides a checklist of information that you'll need to apply for the Health Insurance Marketplace.

3. Compare your options. You'll be able to see all the options you qualify for, including private insurance plans and free and low-cost coverage

through Medicaid or the Children's Health Insurance Program (CHIP). The Marketplace will tell you if you qualify for lower costs on your monthly premiums and out-of-pocket costs for deductibles, copayments, and coinsurance. You'll see details on costs and benefits to help you choose a plan that's right for you.

STOP: If you haven't read the rest of the guide, please finish reading before making a health insurance choice. For some of us, shopping outside of the marketplace for insurance quotes may make sense. This is especially true if you make too much to qualify for cost assistance or if your region has a limited selection of marketplace plans. Regardless of how you shop, you'll benefit from the health insurance advice and definitions in this guide.

4. Enroll. After you choose a plan, you can enroll online and decide how you pay your premiums to your insurer. If you or a member of your family qualify for Medicaid or CHIP, a representative will contact you to enroll. If you have any questions, there's plenty of live and online help along the way.

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FACT: Sometimes the cheapest plan isn't the best one for your needs. Make sure to read the rest of the guide before you enroll.

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Checklist of Information You'll Need to Apply to the Marketplace

For health insurance purposes, your “family” consists of you and every person listed as a dependent on your tax return (even if they live elsewhere). Relatives living with you, who file their own tax return and are not claimed as your dependent need to apply separately. Divorced parents will need to decide who is going to claim children as dependents.

1. Home and/or mailing addresses for everyone applying for coverage.
2. Documentation like “Green Cards”, passport stamps, or visas for legal immigrants.

FACT: “Green Cards” issued from 1977 to 2010 were pink or white, not green! You will be asked to enter a document number. If you have the white version (issued from 1997 to 2010) this consists of three letters and ten digits which are on the right half of the first three lines of data printed on your card.

3. Social Security Numbers for each person applying for coverage.
4. Income information, such as pay stubs or W2 forms, for every person claimed on your 2017 Federal Income Taxes.
5. Your best estimate of your household's projected income during 2017.
6. The policy numbers for any household members who have a current health plan purchased outside the marketplace.
7. Get the “Employer Coverage Tool” completed by an employer for anyone eligible for an employer-based insurance plan, even if they did not enroll in the employer-based plan.

For a blank form visit:

<https://marketplace.cms.gov/applications-and-forms/employer-coverage-tool.pdf>

Automatic Re-enrollment, Switching Plans, & Verifying Information

If you have a marketplace plan from last year, you'll need to log into the marketplace and verify your plan and information. Most plans will automatically re-enroll with similar cost assistance, but plans and cost assistance amounts change, so it's important to verify both of these things.

Plans and information must be verified by December 15th, 2016 to ensure proper coverage and cost assistance on January 1st, 2017.

Automatic Re-enrollment

If you already have a marketplace plan, you will most likely be automatically re-enrolled in the same plan with the same Advanced Premium Tax Credit and the same out-of-pocket Cost Sharing Reduction Subsidy. However, there are many changes in premiums for 2017 and many new plans are available. Also, tax credits can change substantially from one year to the next. In areas where premium rates have risen sharply, you may find that available tax credits have risen and you may be entitled to a lower net premium as a result. In other areas, where there are cheaper plans available this year, your tax credit may have fallen, so the Advanced Premium Tax Credit being deducted each month may be more than you are entitled to. This means it is important to visit the marketplace website, verify the tax credit you are entitled to, and check that this plan is still the best value for your family.

NOTE: In instances where the same plan is not offered, you will be enrolled in a similar plan with similar cost assistance. Make sure to verify this so that you are in control of your coverage. Also, not every plan will be up for automatic renewal. Look out for notices from your marketplace & your insurer for changes in 2017.

Verify Information For Cost Assistance Subsidies

You need to log into the marketplace and verify your information to ensure that you get the right amount of cost assistance in 2016. If you receive too much cost assistance, you could end up owing money back on next year's Federal Income Tax Returns. Update financial information anytime it changes.

Switching Plans

If you won't be automatically re-enrolled or simply want to shop around to see what new plans are being offered, make sure you switch plans during open enrollment. You can switch plans at anytime during open enrollment, but you'll need to enroll by December 15th, 2016 to ensure that you have the plan of your choice by January 1st, 2017.

NOTE: Whether your plan will automatically renew or not, all marketplace coverage obtained before this open enrollment period will end December 31st.

The Health Insurance Marketplace

Your first stop when getting coverage should always be your state's Health Insurance Marketplace. Through your state's marketplace (or the Federal Health Insurance Marketplace, HealthCare.Gov, if your state doesn't have it's own), you'll follow a simple application process which will tell you if you qualify for cost assistance. It will also give you access to all marketplace plans. You aren't making a commitment until you enroll and it is the simplest way to shop for quotes and get cost assistance. It is not, however, your only choice for obtaining minimum essential coverage for health insurance.

Getting Help With The Marketplace

There has been a big effort in most states to employ health insurance navigators to help you with the sign up and enrollment process. Marketplace navigators don't get a commission and their only allegiance is to help you.

1. Get In-person Help.
You can find help, in person, by going to: localhelp.healthcare.gov
2. Call the 24/7 Marketplace Help line: [1-800-318-2596](tel:1-800-318-2596)

The Health Insurance Marketplace Q & A

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ADVICE: We strongly suggest taking the time to speak to a Navigator. The process is less scary when you have someone double checking your work.
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Is it Safe?

If you have been listening to certain media hype, and you may be concerned that your information isn't safe or the site isn't secure. This is not true. The rhetoric you are hearing is simply "what-if" fear mongering to deter you away from taking advantage of the subsidies. The less people experience the benefits of the law, the better chances the anti-ObamaCare folks have to repeal it. At the end of the day, you are sharing basic information (not HIPPA protected information) & obtaining coverage. It is the same information you share with your bank, credit card companies, and more. It's no less safe on the marketplace sites and may be more safe. The website has had almost no reported security issues since it's start in 2013.

Who Can Sign up?

All legal residents of the USA can use the marketplace unless they qualify for Medicare, are incarcerated, or have affordable employer-based coverage meeting the minimum standards.

Can I Change Plans?

If you already have a plan and want to change to a new plan, you must do so during open enrollment. The number of insurers, plans offered, and premium prices in your states' marketplace may have increased this year. Even if you like your current plan, you still may want to change your plan. You must enroll before December 15th to have

coverage that starts January 1st, 2017. Even if you want to stay with your current plan, you should visit the marketplace to calculate the cost assistance you are entitled to and verify your information.

When Does Your Plan Start?

Plans purchased before the 15th of the month typically start on the 1st of the following month. Those enrolled after the 15th, start on the 1st of the month after an entire month has passed.

Making Payments on Your Plan?

Once you are enrolled in an plan, you still have to make a payment before your policy goes into effect. Check with your insurer to understand when your payment is due. We strongly suggest putting your premium payment on auto pay.

What If I Miss a Payment?

Each insurer usually offers a few days grace period for your payment to arrive. Beyond that, if you miss a payment on a marketplace plan, you have 30 days to do so and your insurer still must provide coverage during this grace period.

If you go beyond 30 days past due, you have a total of 90 days to catch up on premium payments, but your insurer can withhold payments to service providers for the latter 60 day period. Additionally, insurers may refuse to pay claims to providers if you are more than 30 days late on payment.

If you miss a payment on a plan you purchased outside of the marketplace, typically, you have 30 days to make the payment before being dropped.

If you get dropped from coverage, you can apply for a new plan within 60 days of losing your plan. This is because you would qualify for Special Enrollment in The Marketplace.

Lowering Your Costs

Whether you are signing up for the first time, changing plans, or your income has changed, you may be eligible for lower costs via cost assistance.

Types of Cost Assistance:

1. Medicaid Health Coverage

(if your state expanded Medicaid)

138% FPL

Individual Annual Income: Up to \$16,394

Family of Four Annual Income: Up to \$33,534

2. Advanced Premium Tax Credits

(caps premiums to lower the amount you pay)

100%-400% FPL in all States

Individual: Between \$11,880-\$47,520

Family of Four: \$24,300-\$97,200

3. Cost Sharing Reduction Subsidies

(lowers out-of-pocket costs on Silver plans)

100%-250% FPL in all States

Individual: Up to \$29,700

Family of Four: Up to \$60,750

FACT: Your assistance is based off of your projected income for 2017. See this link for help calculating assistance for 2017: obamacarefacts.com/obamacare-subsidies/

Getting Cost Assistance

Getting cost assistance is as simple as filling out an application for your states' health insurance marketplace. **Cost Assistance is only available through the marketplace.** This means you won't be able to get cost assistance on a plan purchased outside of the marketplace, even if it is the SAME EXACT plan offered through the marketplace. If you make less than 100% FPL you can't use the marketplace or receive cost assistance.

When you fill out an application, you will be notified if you qualify for cost assistance and the rates you are shown on the marketplace website will reflect that cost assistance. Tax credit subsidies that reduce the cost of your premium can either be taken off the premium up front (advanced tax credits paid to the insurer) or can be deducted from your year end Federal Income Taxes, a decision made when you enroll.

FACT: If your income changes or you qualify for another insurance type (through an employer for example), report it to make sure your tax credits are adjusted. Failing to report an income change could mean you getting the wrong subsidy amount. If you expect your income to change, you may want to consider deferring tax credits until your income taxes instead of getting advanced tax credits.

Federal Poverty (FPL) Guidelines 2016				
	2016 FPL	Medicaid Eligibility	Subsidy Threshold	
Persons in Household	1	\$11,880	\$16,394	\$29,700
	2	\$16,020	\$21,983	\$40,050
	3	\$20,160	\$27,821	\$50,400
	4	\$24,300	\$33,534	\$60,750
	5	\$28,440	\$39,247	\$71,100
	6	\$32,580	\$44,960	\$81,450
	7	\$36,730	\$50,687	\$91,825
	8	\$40,890	\$56,428	\$102,225
Alaska/Hawaii FPL Guidelines 2016				
	Alaska 2016 FPL	Hawaii 2016 FPL		
Persons in Household	1	\$14,840	\$13,670	
	2	\$20,020	\$18,430	
	3	\$25,200	\$23,190	
	4	\$30,380	\$27,950	
	5	\$35,560	\$32,710	
	6	\$40,740	\$37,470	
	7	\$45,920	\$42,230	
	8	\$51,120	\$47,010	

ObamaCare Metal Plans

The health insurance marketplace sells 5 levels of plans nicknamed “metal plans”. In general, the more precious the metal, the better the cost sharing, networks, and benefits, but also, the higher the premium. In practice, only by knowing your subsidy amount, your medical needs, and the specifics of your plan, can you make the best choice between your up-front costs and accrued medical costs over the course of a year.

FACT: All plans offered on The Marketplace must meet certain minimum requirements, such as providing a minimum actuarial value (the percentage of total average costs for covered benefits that a plan will cover for all participants), maximum out-of-pocket costs, and ten essential benefits. Learn more about benefits, rights, and protections offered on all marketplace plans: obamacarefacts.com/benefitsofobamacare/

Metal Plans Include:

Bronze Plans Split Covered Expenses 60-40

Bronze plans are the cheapest because insurers pay, **on average**, only 60% of covered health expenses. The policy holder must come up with the other 40%. In other words, a plan with 60% actuarial value covers an average of 60% of all of your out-of-pocket costs. Bronze plans, in general, have the most basic benefits & the most limited networks of providers. This is a good choice for those who don't plan on using many medical services and don't qualify for Cost Sharing Reduction subsidies (CSR) because their incomes are too high. Bronze plans can often be paired with Health Savings Accounts (HSA) which provides a lot of tax benefits and flexibility. Low-income Americans might qualify for free Bronze plans, but out-of-pocket expenses should be considered because CSR is only available with Silver Plans.

Silver Plans Split Covered Expenses 70-30

Silver plans are the “marketplace standard,” meaning premium caps are based on the cost of Silver plans. A Silver plan on the marketplace can't cost more than 9.5% of your income, if you make less than 400% of the Federal Poverty Level. The less you make, the lower your premium cap is. A Silver level plan is a good choice for those who qualify for subsidies and those who don't. This is because Silver plans are the only plans that offer CSR. If your income decreases unexpectedly to the point you qualify for CSR, you can switch your CSR and out-of-pocket costs you have already spent will count towards your new lower deductible. In addition, some Silver plans will qualify to pair with an HSA if you don't qualify for CSR. You can still use the money already in an HSA for medical expenses even if you qualify for and receive CSR later.

Gold Plans Split Covered Expenses 80-20

Gold plans cost a little more, but the lower

deductibles & better out-of-pocket cost sharing coverage means that families won't have to worry about health care costs as much beyond the premiums. You'll have to pay more in premiums if you want a gold plan.

Platinum Plans Split Covered Expenses 90-10

Platinum plans have the lowest out-of-pocket costs & the highest monthly premiums. This is the right choice for anyone who wants “the best coverage” for them & their family. It is a smart buy for those who have chronic disease and high incomes.

Catastrophic Coverage

Catastrophic coverage is available to people under 30 and those with hardship exemptions. Catastrophic plans only cover the minimum essential benefits before the deductible is met & they have a very limited network. You'll have high out-of-pocket costs & a high deductibles, but the monthly premiums will be significantly lower. This type of plan will protect you in a worst-case-scenario, protect you from the fee, & they are only available outside the health insurance marketplaces. These plans also usually qualify to be paired with an HSA, so it is a good choice for young healthy individuals who want to save money on premiums to place in an HSA. It is also a good choice for those who use conventional medicine only as a last resort, because HSAs allows greater flexibility for what qualifies as a medical expense than most insurers.

ADVICE: We suggest a Silver plan (or higher) in most cases. If you don't qualify for subsidies, a Silver plan that pairs with an HSA is likely the best option. For the young & healthy, a Catastrophic plan is also a good choice, if you put your premium savings in an HSA. Take into consideration premium costs, deductibles, subsidies, & HSA eligibility (tax benefits): all of these will factor into your total costs/savings.

The Employer Mandate

In 2016 all large employers are required to offer health coverage to almost all their full-time employees. You'll want to double check that your employer is offering coverage that is considered affordable for you and/or your family even if it meets the rules for your employer per the Employer Mandate. If employer coverage is less than 9.69% of the employee's income for self-only coverage, than the employee (and his family) aren't eligible for cost assistance on the marketplaces. However, if coverage is more than 8.16% of the familie's income, you may apply for an exemption from the Individual Mandate to have health insurance.

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FACT: Businesses with 50-99 full-time equivalent employees (FTE) needed to start insuring workers by 2016. Those with a 100 or more needed to start providing health benefits to at least 70% of their FTE by 2015 and 95% by 2016. Health Care Tax Credits have been retroactively available to small businesses with 25 or less full-time equivalent employees since 2010.
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Making Sure Your Employer Sponsored Coverage is ACA Compliant

If your employer offers coverage, chances are that you won't be eligible for cost assistance and the employer based coverage will be your best option. However, there are a few tests to ensure that your employer sponsored coverage is meeting the ACA guidelines. If it is not, you and/or your family may be eligible for marketplace cost-assisted insurance.

It must offer:

- At least The Ten Essential Benefits
- At least 60% actuarial value (your average share of medical bills is at least 40%)
- It must have limits on out-of-pocket costs
- Your employer must pay at least half of your health insurance premium.
- Employee only coverage can't cost more than 9.69% of employee only income.

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NOTE: If the employer doesn't offer a family plan, the rest of your family can still use the marketplace to get insurance, tax credits, & subsidies.

NOTE: If your family has access to your employer's plan they may not qualify for tax credits or subsidies in the healthcare marketplace.

NOTE: If you want to get marketplace insurance, but you have access to your employer's coverage please ask your employer to fill out this form before you apply:

<https://marketplace.cms.gov/applications-and-forms/employer-coverage-tool.pdf>
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Image from: facebook.com/Healthcare.gov

Buying Private Health Insurance Outside of the Marketplace

For those projecting to make more than 400% of the Federal Poverty Level (\$47,520 as an individual or \$97,200 as a family of four in 2017) it may be smart to shop for coverage outside of the health insurance marketplaces. This is because in some states and in some regions the marketplace only offers a portion of all plans available. Depending on your region and your cost assistance eligibility you may want to shop outside the marketplace to see how private off-marketplace plans compare.

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FACT: In some states, your cheapest plan will be found on the marketplace, even without cost assistance. In other cases, shopping outside of the marketplace will help you find the best plan for you & your family. The only way to find out all of your options is to shop around for health quotes during open enrollment 2017.
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Shopping Outside the Marketplace

1. **Contact an Insurance provider to compare & buy insurance health plans.** Your choices will be limited to plans that insurer offers.
2. **Speak to a Broker or Agent to buy & compare health plans:** You can speak to an Agent on the phone, in person, or use an online broker. They can help you find your best options for purchasing health insurance and give you quotes from many providers.

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FACT: A specific plan, in a specific region, can never cost more than in another region. Insurers always pay fees direct to agents and brokers so you'll never pay the extra costs for getting help.
FACT: Open enrollment applies outside the marketplace as well. Since 2014, all private insurers have adopted the Health Insurance Marketplace's enrollment periods
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Explore your coverage options, call 1-877-591-5398 for off-marketplace help.



Let's Talk About the Essential Health Benefits Included On All Plans

The Affordable Care Act states that at least Ten Essential Health Benefits must be included on all major medical plans sold in the markets. This is true no matter where you get your plan. Some of these benefits are included at no out-of-pocket cost before your deductible, but most are simply covered at your plans cost-sharing amount after you meet your deductible.

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FACT: Each qualified plan must offer Essential Health Benefits which, overall, are equal to the scope of benefits typically covered by employers, as shown by a Department of Labor survey of employer-sponsored coverage. (Ref: ACA, Section 1302 (b) (2) (a))
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The Ten Essential Benefits

1. Ambulatory Patient Services (Outpatient Care)
Care you receive without being admitted to a hospital, such as at a doctor's office, clinic or same-day ("outpatient") surgery center. Also included in this category are home health services and hospice care.

NOTE: Some plans may limit coverage to no more than 45 days.

2. Emergency Services (Emergency Room Care)
Care you receive for conditions that could lead to serious disability or death if not immediately treated. This includes accidents or sudden illness. Typically, this is a trip to the emergency room & includes transport by ambulance. You cannot be penalized for going out-of-network or for not having prior authorization.

3. Hospitalization (Treatment in a Hospital)
Care you receive as a hospital patient, including care from doctors, nurses & other hospital staff, laboratory & other tests, medications you receive during your hospital stay, as well as, room & board. Hospitalization coverage also includes surgeries, transplants & care received in a skilled nursing facility, such as a nursing home that specializes in the care of the elderly

NOTE: Some plans may limit skilled nursing facility coverage to no more than 45 days.

4. Maternity, Prenatal & Newborn Care (Obstetrics)
Care that women receive during pregnancy, throughout labor, delivery, post-delivery, & care for newborn babies.

5. Mental Health Services & Addiction Treatment
Inpatient & outpatient care provided to evaluate, diagnose, & treat a mental health condition or substance abuse disorders. This includes behavioral health treatment, counseling & psychotherapy.

NOTE: Some plans may limit coverage to 20 days each year. Limits must comply with state or federal parity laws.

6. Prescription Drugs
Medications that are prescribed by a doctor to treat an illness or condition. Examples include prescription antibiotics to treat an infection or medication used to treat an ongoing condition, like high cholesterol. At least one prescription drug must be covered for each category & classification of federally approved drugs. However, limitations do apply & some prescription drugs can be excluded. "Over the counter" drugs are usually not covered even if a doctor writes you a prescription for them.

Insurers may limit drugs they will cover and/or cover only generic versions of drugs when generics are available. Some medicines are excluded when a cheaper & equally effective medicine is available, or the insurer may impose "Step" requirements. For example, expensive drugs can only be prescribed if doctor has tried a cheaper alternative & found that it was not effective. Some more expensive drugs will need special approval.

7. Rehabilitative Services & Devices

Rehabilitative services or help recovering skills, like speech therapy after a stroke & habilitative services & help developing skills, like speech therapy for children. In addition, devices to help you gain or recover mental & physical skills lost because of injury, disability, or chronic condition. This also includes devices needed for "habilitative reasons". Plans have to provide 30 visits each year for either physical therapy, occupational therapy, or visits to a chiropractor. Plans must cover 30 visits for speech therapy & 30 visits for cardiac or pulmonary rehab.

8. Laboratory Services

Testing provided to help a doctor diagnose an injury, illness or condition, or to monitor the effectiveness of a particular treatment. Some preventive screenings, such as breast cancer screenings and prostate exams, are provided at no cost before your deductible is met.

9. Preventive Services, Wellness Services, & Chronic Disease Treatment.

This includes counseling, preventive care like annual physicals, immunizations, & screenings like cancer screenings, & designed to prevent or detect medical conditions. Also, care for chronic conditions, such as asthma & diabetes.

NOTE: Please see our full list of preventive services for details on which services are covered under The Ten Essential Benefits.

obamacarefacts.com/obamacare-preventive-care/

10. Pediatric services

Care provided to infants & children including well-child visits & recommended vaccines. Dental & vision care must be offered to children younger than 19. This includes two routine dental exams, an eye exam & corrective lenses each year if they are prescribed.

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FACT: While all qualified plans must offer the ten essential benefits, the scope & quantity of services offered under each category can vary.
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Insurance Plan Types & Types of Savings Accounts for Medical Costs

There are four types of health insurance plans: Health Maintenance Organizations (HMOs), Participating Provider Options (PPOs), Exclusive Provider Organizations (EPOs), and Point of Service (POS) Plans. Consumer Directed Health Plans (CDHPs) can be paired with Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), or, on some grandfathered plans, Archer Medical Savings Accounts (MSAs); allowing employers, employees, or self-employed individuals to contribute tax free dollars towards their medical expenses.

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FACT: A PPO doesn't require that you get a referral from a doctor before getting treatment from out-of-network like an HMO. Regardless of your plan, if you get services out-of-network you will have to pay more for those services.
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Insurance Plan Types

HMO Health Maintenance Organization plans often offer the best pricing & the least flexibility. They serve up lower prices by limiting your providers to the doctors, clinics & hospitals within the HMO's network. HMOs require you to choose a primary care physician (PCP) who coordinates your health care & provides you referrals before you are able to get treatment from other network providers or specialists. If you go out outside the network, your services won't be covered except treatment for medical emergencies, which is one of the Ten Essential Benefits discussed in the previous section.

PPO Preferred Provider Organization plans offer networks of doctors, hospitals & clinics that are deemed "preferred providers." Go to them for treatment & you get lower rates negotiated by the insurance company. However, PPOs provide more flexibility than HMOs because they allow you to seek care outside the network, though doing so, will likely cost you more in deductibles & co-pays. Unlike HMOs, PPOs don't require you get a doctor referral before you see a specialist. Many of the plans do require prior approval for certain expensive services.

POS Point of Service plans can reduce your out-of-pocket costs by choosing providers in the network, but allowing you to seek services outside the network and pay more. It's your choice. The exact definition varies from one state to another. Many POS plans are more like a HMO, in that they require you to choose a PCP and get referrals for specialist care. Some even cover higher costs if your PCP decides to refer you to an out of network specialist.

EPO Exclusive Provider Organizations plans offer 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 situation.



Types of Savings Accounts

FSA Flexible Spending Account. FSAs are set up through an employer plan & they allow you to set aside pre-tax dollars for certain health and dependent-care needs. For example, the money can be used to pay for deductibles, prescription co-pays and other treatments not covered by your insurance.

A big downside for many: whatever you don't use by the end of your company's benefits year will be forfeited. Check with your employer's Human Resources department for specifics on their FSA. They can provide a list of FSA-qualified costs that you can purchase directly or be reimbursed for. A few common FSA-qualified costs include:

- Copays for medical treatments & doctor visits,
- Hospital & doctor fees for medical tests & services (for example, X-rays & cancer screenings).
- Physical Rehabilitation.
- Dental & Orthodontic expenses (like getting a cleaning, fillings, or braces).
- Inpatient treatment for alcohol or drug addiction.
- Over-the-counter medications and sometimes vitamins recommended by a doctor.
- Vaccines (immunizations) & flu shots.

MSA "Archer" Medical Savings Account. The Archer MSA was intended to be used by self-employed individuals & small businesses with fewer than 50 employees. The plan is entirely self-directed, including its initial setup & compliance with the plan thresholds. It works very closely to HSAs & have been replaced by HSAs since 2007. However some grand-fathered plans may still use MSAs that have been "left open".

HSA Health Savings Account. HSAs are tax-preferred savings accounts available to those enrolled in high deductible health plans (HDHP). In 2017, any plan with a deductible more than \$1,300 for an individual or \$2,600 for a family is usually a HDHP. Employers & employees are allowed to contribute to them. The maximum tax-free contributions for 2017 are \$3,400 for an individual and \$6,750 for a family and an additional \$1,000 for each individual over 55.

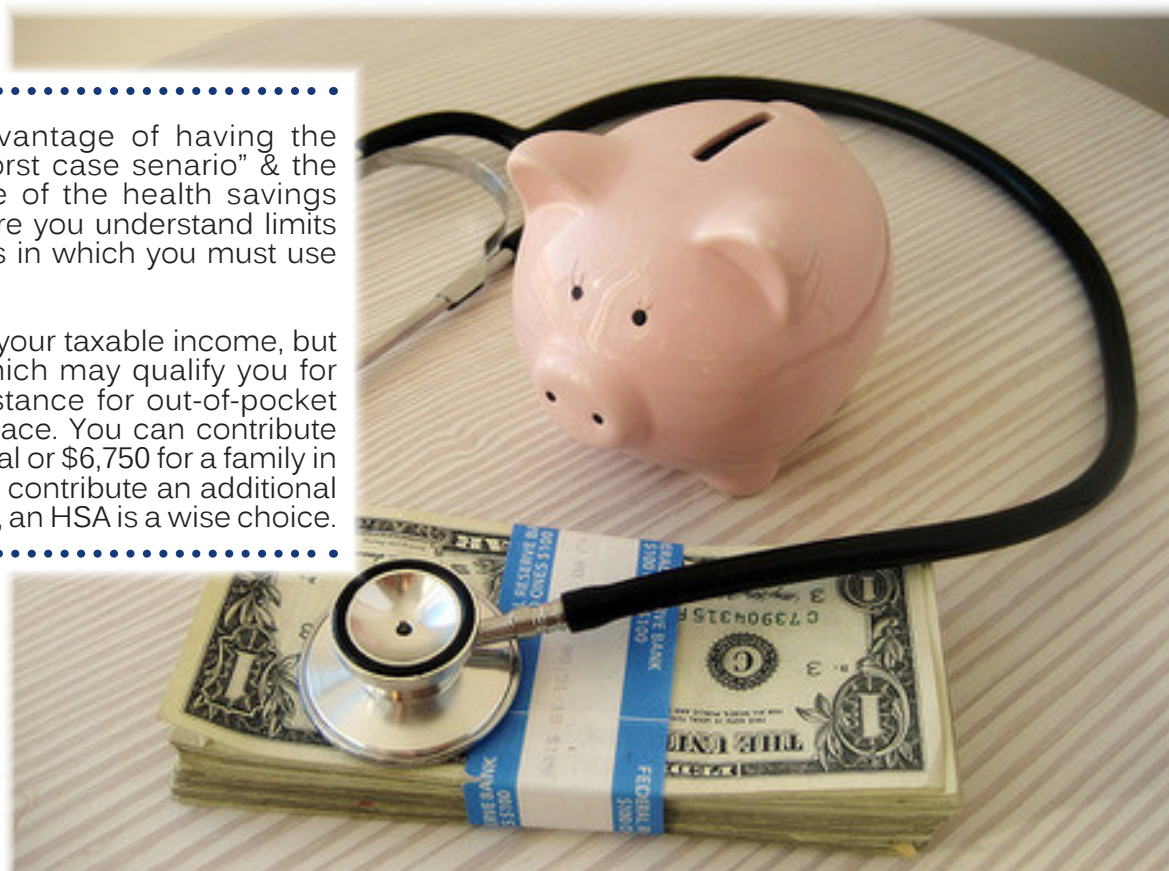
HSAs allow you to set aside tax-free dollars to pay for out-of-pocket medical expenses for covered individuals and their family. You also pay no federal income taxes on interest earned by your HSA, so long as you use the money to pay for eligible medical expenses, as defined by the IRS. Dental & vision are included, as well as, dependent care.

Unlike an FSA, HSA funds roll over annually & accumulate, even if an employee changes jobs. The accumulated funds can be removed for non-eligible expenses, but then will be subject Federal Income Tax and 20% penalty. Once an individual qualifies for Medicare these accumulated funds can still be used tax free for medical expenses Medicare doesn't cover or can be used like an IRA or 401k (however you'll still have to pay taxes on this, but no penalty).

Should a person decide they no longer want to use a HDHP, funds already saved can still be spent on medical expenses or rolled into an IRA retirement account without facing taxes or penalties. Funds placed in an HSA reduce your Adjusted Gross Income (AGI) and Modified Adjusted Gross Income (MAGI). MAGI is used for calculating PTCs. Both reductions potentially mean either getting a larger return or owing less on your year-end taxes.

ADVICE: Consider the advantage of having the money to pay for the "worst case scenario" & the tax benefits of using one of the health savings accounts above. Make sure you understand limits on the accounts & periods in which you must use the funds if applicable.

FACT: HSAs not only lower your taxable income, but they lower your MAGI, which may qualify you for more subsidies and assistance for out-of-pocket expenses on the marketplace. You can contribute up to \$3,400 for an individual or \$6,750 for a family in 2017 & people over 55 can contribute an additional \$1,000. If you have a HDHP, an HSA is a wise choice.



The Importance of Networks

One of the biggest complaints people have once they start using their insurance is that the drugs they need aren't covered or the doctor they want to see isn't in the plan's network. This is because every plan has a different network.

A narrow network HMO may save you 25%, or more, in premiums compared to a PPO plan. Many of the cheaper marketplace HMO plans have a more restrictive networks of providers than other HMO plans offered by the same company. Be sure that you check providers accept the exact plan you have. Since these "narrow networks" often pay less than the insurer's other plans, some doctors are reluctant to accept patients who are covered by these plans. This may be true even if the doctor's contract with the insurer requires him to be listed

in that plan provider directory. Always check with doctor's office that they do, in fact, accept your insurance plan. Don't rely on lists from the insurer.

Bear in mind that there is nothing wrong with a narrow network, provided that it includes the doctors and hospitals that you prefer. Some marketplace plans are offered by companies who traditionally only run Managed Medicaid plans, and their networks mainly consist of public clinics, non-profits, and other low-cost providers who primarily serve Medicaid customers. In other cases, an insurer has managed to negotiate low rates by choosing one hospital network and its associated physicians; excluding all its rivals. If the selected hospital network includes the hospitals you like there is no disadvantage to the narrow network.

Drug Formulary (Drug list): A list of prescription drugs covered by the plan. Usually these drugs will be arranged in between three and five "cost tiers".

A three tier system may have "generics," "preferred brand name drugs", and "other". A five tier system often divides generic and brand name drugs into two cost tiers and adds a "Specialised" tier for very expensive uncommon drugs.

If you have regular medications you take, check the cost of each carefully. One company may place a drug in a different price tier, or may even exclude it altogether. This is especially true of more expensive medications and brand names versions which have a cheaper generic version available.

Sometimes an insurer may deliberately exclude a drug from its formulary in order to discourage particular patients from signing up. A Florida law suit alleges that Humana illegally discriminated against HIV positive patients by excluding a number of generic drugs used to treat HIV from its formulary.

Another common complaint is that the formulary may omit the newer drugs to treat ADHD, such as Vyvanse or Concerta, or even the generic form of Concerta, forcing patients to use the cheap, but less effective fast-acting amphetamines, which can be abused and lead to addiction problems.

Keep in mind prices for prescription medicines vary greatly from one pharmacy to another. Although each plan has agreed a price schedule with the pharmacies, a plan may force you to go to a pharmacy that charges more. To look at comparative prices visit: GoodRX.com

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

Covered Treatments: The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in State program rules.

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FACT: In general, the more expensive your plan the more likely it is you'll spend less time waiting for appointments. Cheaper plans attract more new enrollees. These enrollees need to see in-network doctors, those doctors get overwhelmed, & this creates longer waiting periods. Of course this is only a rule of thumb & one could very well find an expensive plan will offer the same network as a cheaper plan because networks are contracted.

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ADVICE: The covered benefits of your plan and what doctors, drugs, and treatments are covered under that plan are available via a standardized benefit sheet for each plan. If you have a plan that doesn't provide the coverage you need, we advise you to switch to a different plan during your open enrollment period.



Doing the Math

So when it comes right down to it, you'll have to choose a plan based on your own projected medical needs, the needs of your family, and the information you found in this guide. So let's take a quick review of some important points.

FACT: Most people's medical expenses will be doctor office visits, therapists, & prescriptions. Many plans cover all these with copayments. These services could easily add up to \$5,000 or more a year before insurance. This could make a big difference between plans that have \$10 copays and those with \$40 copays.

- When in doubt, choose a HMO over an PPO. You may have more freedom, in general when choosing healthcare providers on a PPO, and will avoid the need for referrals, but HMOs tend to have a far cheaper price tag.
- If you project having a lot of medical expenses or use a lot of medications, get a plan with a large doctor network & drug formulary.
- Make sure your network includes your family doctor or any other doctor you'd like to see or hospital you'd like to use.
- Make sure your drug formulary covers the drugs you normally use with reasonable copays.
- If you project to have medical expenses, you'll likely want a plan with the great coinsurance, lower copays, and a lower deductible. This may be more important than your premium. That being said, some insurers over charge premiums for low-deductible plans so much that the lower deductible plan might actually cost more in premiums than you will save on deductible. **Always compare the deductibles & the yearly premium costs of plans.**
- We can compare a handful of plans that have similar premiums, but wildly different deductibles, coinsurances, copays & networks. You need to know what is the most important for you & your family.

If You:

Plan to Use a lot of Medical Services

The aspects of your plan that are the most important (in order of priority):

1. Network
2. Copay (and benefits before deductible)
3. Deductible & HSA eligibility
4. Coinsurance
5. Premium

Don't Plan on Medical Expenses

The aspects of your plan that are the most important (in order of priority):

1. Premium
2. Deductible & HSA eligibility
3. Copay (and benefits before deductible)
4. Network
5. Coinsurance



Image from: facebook.com/Healthcare.gov

Using Your Coverage

Okay, let's assume the information you've read so far has given you all the knowledge you need to get the right plan for you and your family, That rocks! Welcome to the security of knowing you have all the information to get coverage. Now let's check out a few smart things to do to get started.

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For more information about using your coverage:
<http://marketplace.cms.gov/outreach-and-education/downloads/c2c-roadmap.pdf>
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Stay Healthy: This isn't meant to be rhetorical. Simply speaking, the best way to use your coverage is to not need to & use it for more than prevention. Maintain a healthy exercise routine & a healthy diet & you're half the way there. You'll also want to get all your preventive medicines & screenings & book your free annual wellness visit.

Understand Your Network's Options: We would love to tell you the next step is finding your healthcare providers (family doctor, other docs you know you need). However, the truth is, your plan is going to dictate your options. Check out your plans network & find the providers who will meet your needs. Don't hesitate to check online reviews. You'll also want to check for hospitals that are in-network & understand what medications you may need that are covered in your plan's drug formulary.

Book Your Appointments: Now that you know what healthcare providers you'll need, you simply have to schedule an appointment. Don't get discouraged if there is a long wait time, tens of millions of folks, are getting insured for the first time during open enrollment 2016. This is a busy season for booking your free annual wellness visit & getting established with a primary care doctor.

Prepare For Your Visit: This may be the first time at the doctors in some time, so you may want to gather all of your family history, past medical records, your insurance card, & anything else you may need. Write down questions & bring along someone who knows you & cares if you need help.

Get the Most Out of Your Visit: Your doc is going to have a good idea of what you need for your checkup, but please make sure to ask them to ensure you are up-to date on preventive measures. You'll want to have all screenings & vaccinations done for someone your age. Trust your doctor & tell them everything. Hiding something can be tempting, but to treat you properly, it's important that your healthcare providers have all the facts.



REMEMBER: if you didn't use your insurance for more than the basics this year that is a good thing. Having insurance is about not needing to worry, not putting off treatment due to cost, & knowing that when you need it, you are covered.

Understanding Health Insurance

Now that you know the minimum benefits each plan will include, let's look at how to understand health plans a little more in-depth.

In order to get the right plan for your family, you need to understand the health insurance jargon and plan information that you'll find on a basic benefits sheet. You can't very well compare plans without knowing the difference between HMO's and PPO's; or get the best bang for your buck without understanding your projected health care needs vs. a plans network, premium, deductible, out-of-pocket maximums, coinsurance and more. Let's take a quick look at all of these terms and talk about why they are important.

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FACT: The truth is, most private major medical insurance & all public insurance is heavily regulated. Getting the best deal often boils down to understanding your projected medical needs for the year & weighing that against your the insurance plan's cost, coverage, & limits, as well as, how to take advantage of the various tax deductions available for medical care costs.
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Definitions:

Actuarial Value The percentage of total average costs for covered benefits that a plan will cover for all participants. 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. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

Advanced Premium Tax Credit The Affordable Care Act provides a new tax credit to help you afford health coverage purchased 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.

Allowed Amount The amount that an insurer has agreed to pay its network providers for a service. This is often a fraction of the "list price" for that service and is the maximum you will pay if you go to an in-network provider.

Definitions from medmutual.com & healthcare.gov

Benefit Period A benefit period is the length of time during which a benefit is paid. It also defines the time when benefit maximums, deductibles & coinsurance limits build up. It defines the number of a specific treatments you may be allotted in a given time period. It has a start & end date. It is often one calendar year for health insurance plans. Although many essential treatments have no life-time or annual dollar limits, non-essential benefits may still be subject to benefit periods. In addition, at the end of each period your deductible & out-of-pocket maximums will be reset.

Coinsurance Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. 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.

Coinsurance Limit (or Maximum) The maximum amount you will pay in coinsurance costs during a given benefit period.

Condition An injury, ailment, disease, illness, or disorder diagnosis.

Contract The agreement between an insurance company & the policy holder.

Definitions continued...

Copayment (AKA Copay) A fixed amount you pay to a healthcare provider at the time you receive medical services. You may have to pay a copay for each covered visit to the doctor or facility providing services, depending on your plan. Not all plans have a copay.

Cost Assistance Help paying your medical costs, commonly in the form of subsidies through the Health Insurance Marketplace or a publicly funded program like Medicaid or Medicare.

Cost Sharing The part of costs for medical services that you have to pay “out of your own pocket”. It includes deductibles, copayments and coinsurance.

Cost Sharing Reduction A discount that lowers the amount you pay out-of-pocket for deductibles, coinsurance, & copayments. You can get this reduction if you get health insurance through The Marketplace, your income is below a certain level, & you choose a health plan from the Silver plan category (See types of Marketplace plans in the following section). If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.

Covered Charges Charges for covered services that your health plan pay for. There may be a limit on covered charges if you receive services from providers outside your plan's network of providers.

Covered Person/s Any person or persons covered by an insurance plan.

Covered Service A healthcare provider's service or medical supplies covered by your health plan. Benefits will be given for these services based on your plan's coverage.

Creditable Coverage Coverage of a person or persons under any of these:

- A Group Health Plan. This includes church & governmental plans
- Health Insurance Coverage
- Medicare (Part A or Part B of Title XVIII of the Social Security Act)
- Medicaid (Title XIX of the Social Security Act, other than coverage consisting only of benefits under Section 1928)
- A health plans for active military personnel. This includes TRICARE
- The Indian Health Service or other tribal related organization programs
- A State's health benefits risk pool
- The Federal Employees Health Benefits Program.

- A public health plan (as defined by federal regulations)
- A health benefit plan under section 5 (c) of the Peace Corps Act
- Any other plan which gives complete hospital, medical & surgical services

Deductible The amount you have to pay before your plan helps with any medical expenses. Deductibles are based on your benefit period.

EXAMPLE: If your deductible is \$1,000, your plan won't pay anything until you've met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

ADVICE: It is important to understand that deductibles are defined differently by different plans. Some apply the deductible to all services, others only apply the deductible to services that do not have a copayment. These plans may for example have copayments for primary care, mental health and specialist office visits and most prescription drugs, so your plan will pay part of the cost of these services even if you have not met your deductible yet. Another plan may expect you to pay for all costs until you meet your deductible, with the copayment only applying after that point.

Also some plans have a separate deductible for prescription benefits. Even if you haven't met your deductible it is important to show your insurance card: it will generally entitle you to the much lower rates that your insurance company has negotiated with that provider.

Dependent Coverage Coverage for your dependents who qualify.

Emergency Medical Condition like a medical problem with sudden & severe symptoms that must be treated quickly. In an emergency, a person with no medical training & an average knowledge of health/medicine could reasonably expect the problem could:

- Put a person's health at serious risk
- Put an unborn child's health at serious risk
- Result in serious damage to the person's body & how his or her body works
- Result in serious damage of a person's organ or any part of the person

Experimental or Investigational Drug, Device, Medical Treatment or Procedure These are not approved by the U.S. Food & Drug Administration (FDA) or are not considered the standard of care.

Definitions continued...

Exclusions Exclusions are medical services that the insurance policy does not cover.

Health Assessment A health survey that measures your current health, health risks & quality of life.

Inpatient Services Services received when admitted to a hospital or skilled nursing facility (nursing home), including room & board charges.

Institution (Institutional) A hospital or certain other facilities like skilled nursing facilities.

Legal Guardian The person who takes care of a child & makes healthcare decisions for them. This person is a biological parent or was made the child's custodian by a court of law.

Long-term Insurance A type of health insurance that covers certain services over a set amount of time (typically a 12 month period). Intended to cover at least 6 months, as opposed to short term insurance-

Major Medical Insurance Health insurance designed to cover medical expenses due to severe or prolonged illness by paying all or most of the bills above a set amount.

Medical Care Medical services received from a healthcare provider or facility to treat a condition.

Medically Necessary (or Medical Necessity) Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:

- Accepted as standard practice
- Not just for your convenience or the convenience of your provider
- The right amount of service that can be given to you for a given condition

EXAMPLE: Inpatient care is medically necessary if treatment can't be given using outpatient services.

Medicare A federal program for people age 65 or older that pays for certain healthcare expenses.

Metal Plan A type of plan sold through the health insurance marketplace. In general, the more precious the metal, the more a plan will cost, but the better the coverage & cost sharing is.

Minimum Essential Coverage The minimum medical coverages that protects you from the fee.

Non-covered Charges Charges for services & supplies that are not covered under the health plan.

EXAMPLE: These may include things like acupuncture, weight loss surgery & marriage counseling. Consult your plan for specifics about what is covered.

Non-network Provider/Out-of-network Provider A healthcare provider who is not part of a plan's network. Costs associated with out-of-network providers are usually higher or not covered at all. Consult your insurance plan for more information.

Outpatient Services Services that do not need an overnight stay in a hospital. These services are often provided in a doctor's office, hospital or clinic.

Out-of-pocket Cost Cost you must pay. Out-of-pocket costs vary by plan & each plan has a maximum out of pocket cost. Consult your plan for more information.

Network Provider/In-network Provider A healthcare provider who is part of a plan's network.

Prescription Drug Any medicine that may not be given without a prescription from a doctor because of federal or a State's laws.

Premium Payments you make to your insurance provider to keep your coverage. The payments are due at certain times.

Preexisting Conditions This is something someone had before obtaining the insurance policy. Some plans will cover pre-existing conditions while others may completely exclude them, In addition, some health insurance plans will cover pre-existing conditions after a certain time period.

Provider (Healthcare Provider) A hospital, facility, physician, or other licensed healthcare professional.

Short-term Insurance A type of health insurance that covers certain services for a set time period (6 months or less). Learn more about short-term insurance here: <http://obamacarefacts.com/insurance-exchange/short-term-health-insurance/>

Urgent Care Provider A provider of services for health problems that need medical help right away but are not emergency medical conditions.

Waiting Period This is the time one would have to wait until certain coverages are available. This no longer applies to individual plans and is limited on Employer plans. It still applies to short-term coverage.

EXAMPLE: An employer's insurer may require a waiting period of 90 days before coverage begins.

