GLOSSARY OF KEY AFFORDABLE CARE ACT AND COMMON HEALTH PLAN TERMS

Note: in the event of any conflict between this glossary and your plan document/summary plan description (SPD) or policy/certificate, the terms of your document, SPD, policy, or certificate will control. In addition, these definitions may be subject to modification based upon subsequent guidance that clarifies or amends Affordable Care Act provisions.

------ A ------

ACA – See Affordable Care Act.

Accountable Care Organization (ACO) – A group of health care providers that provides coordinated care and chronic disease management, thereby improving the quality of care received by patients. The organization's payment is related to achieving health care quality goals and outcomes that result in cost savings.

ACO – See Accountable Care Organization.

Actuarial Value (AV) – A measure of a plan’s generosity; it is the percentage paid by the plan of the total allowed costs of benefits. Beginning in 2014, all non-grandfathered health plans in the individual and small group markets (both inside and outside the Health Insurance Marketplaces) must meet specified actuarial values, which are also known as "metal levels" (60% = bronze plan; 70% = silver plan; 80% = gold plan; 90% = platinum plan). To determine actuarial value, plans can use calculators or design-based safe harbor checklists provided by the U.S. Department of Health and Human Services, or can hire an enrolled actuary to provide an actuarial certification.

Affordable Care Act (ACA) – The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

Affordable Insurance Exchange – See Health Insurance Marketplace.

Allowed Amount – The maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance,” or “negotiated rate.” If a provider charges a covered individual more than the allowed amount, he or she may have to pay the difference. (See Balance Billing.)

Annual Limit – A cap on the benefits that will be paid in a year while an individual is covered by a health plan. These caps are sometimes placed on particular services. Annual limits may be placed on the dollar amount of covered services or on the number of visits or treatments that will be covered for a particular service. After an annual limit is reached, the covered individual must pay all associated health care costs for the rest of the year. Beginning in 2014, the ACA prohibits annual dollar limits on essential health benefits.

Appeal – A request for a covered individual’s health insurer or plan to review a decision or a grievance again.

Automatic Enrollment – The ACA requires most employers with more than 200 full-time employees to establish a process to enroll all eligible workers in a health plan unless the worker tells the employer otherwise during the enrollment period. The effective date of this ACA provision has been delayed.

AV – See Actuarial Value.

------ B ------

Balance Billing – Balance billing occurs when a provider bills a covered individual for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill the covered individual for the remaining $30. A preferred provider may not balance bill a covered individual for covered services.

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

------ C ------

Cadillac Tax . See High Cost Excise Tax.

Care Coordination . The organization of an individual's treatment across several health care providers.

Children's Health Insurance Program (CHIP) . An insurance program jointly funded by state and Federal government that provides health insurance to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage.

CHIP . See Children's Health Insurance Program.

Chronic Disease Management . An integrated care approach to managing illness that includes screenings, check-ups, monitoring and coordinating treatment, and patient education. For an individual with a chronic disease, it can improve the individual's quality of life while reducing his or her health care costs by preventing or minimizing the effects of the disease.

Claim . A request for payment that the covered individual or his or her health care provider submits to the covered individual's health insurer or plan when the covered individual receives items or services they think are covered.

COBRA . A Federal law that may allow an individual to maintain health coverage temporarily after his or her employment ends, the individual loses coverage as a dependent of the covered employee, or another qualifying event. If an individual elects COBRA coverage, he or she pays 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Co-insurance . A covered individual's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. The covered individual pays co-insurance plus any deductibles he or she owes. For example, if the health insurance policy's or plan's allowed amount for an office visit is $100 and the covered individual has met the deductible, his or her co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Community Rating . A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status, or other factors.

Comparative Effectiveness Research (CER) Fee . See Patient-Centered Outcomes Research Institute (PCORI) Fee.

Consumer Operated and Oriented Plan (CO-OP) - A qualified health plan that will be sold by member-owned and operated non-profit organizations through Health Insurance Marketplaces.

Conversion . The ability, in some states, to switch an individual's employment-based coverage to an individual policy when he or she loses eligibility for employment-based coverage.

CO-OP . See Consumer Operated and Oriented Plan.

Co-payment . A fixed amount (for example, $15) a covered individual pays for a covered health care service, usually when he or she receives the service. The amount can vary by the type of covered health care service.

Cost Sharing . The share of costs covered by an insurance policy or plan that a covered individual pays out of his or her own pocket. This term generally includes deductibles, co-insurance, and co-payments, or similar charges, but it does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. The ACA provides reduced cost sharing to eligible individuals and families based upon income.

------ D ------

Deductible . The amount a covered individual owes for health care services covered by his or her health insurance policy or plan before the policy or plan begins to pay. For example, if an individualqs deductible is $1000, the plan will not pay anything until the covered individual has met the $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. Beginning in 2014, non-grandfathered health plans offered in the small group market (inside and outside the Health Insurance Marketplaces) must limit annual deductibles to $2000 single/$4000 family. These amounts will be indexed in subsequent years. Some small group coverage may exceed the annual deductible limit if doing so is necessary to reach a given %metal tier+level of coverage.

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

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

------ E ------

EHBs . See Essential Health Benefits.

Employer Mandate . See Employer Shared Responsibility.

Employer Shared Responsibility (also called %Employer Mandate+ or %Pay or Play Mandate+) . Under the ACA, starting in 2014, if an employer with at least 50 full-time equivalent employees does not offer minimum essential coverage that is affordable and provides minimum value and an employee uses a tax credit (subsidy) to help pay for insurance through a Health Insurance Marketplace, the employer must pay a fee to help cover the cost of the tax credits.

EPO Plan . See Exclusive Provider Organization (EPO) Plan.

Essential Health Benefits (EHBs) - A set of health care service categories that must be covered by certain plans, starting in 2014.

The ACA ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplaces, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplaces, and all Medicaid state plans must cover these services by 2014.

Starting with plan years or policy years that began on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for these services. All plans, except grandfathered individual health insurance policies, must phase out annual dollar spending limits for these services by 2014.

Exchange . See Health Insurance Marketplace.

Exclusive Provider Organization (EPO) Plan . A managed care plan where services are covered only if a covered individual goes to doctors, specialists, or hospitals in the planqs network (except in an emergency).

External Review . The ACA requires all health plans (except grandfathered health plans) to provide an external review appeal process.

------ F ------

Family and Medical Leave Act (FMLA) . A Federal law that entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health coverage under the same terms and conditions as if the employee had not taken leave.

Federal Poverty Level (FPL) . A measure of income level issued annually by the U.S. Department of Health and Human Services. The federal poverty level is used to determine an individualqs eligibility for certain programs and benefits, including subsidies that can be used to buy health insurance through the Health Insurance Marketplaces.

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

FMLA . See Family and Medical Leave Act.

Formulary . A list of drugs a covered individualqs health plan covers. A formulary may include how much the covered individual must pay for each drug. (If the plan uses %tiers,+ the formulary may list which drugs are in which tiers.) Formularies may include both generic drugs and brand-name drugs.

FPL . See Federal Poverty Level.

FTE . See Full-Time Employee.

Full-Time Employee (FTE) . Under the employer shared responsibility provisions of the ACA, a full-time employee is an individual who is employed on average at least 30 hours per week in any month or has worked a total of 130 hours in the month.

------ G ------

Grandfathered Health Plan . A group health plan that was created, or an individual health insurance policy that was purchased, on or before March 23, 2010, which elected grandfathered status. Grandfathered health plans are exempt from many changes required under the ACA. Plans or policies may lose their %grandfathered+ status if they make certain significant changes that reduce benefits or increase costs to covered individuals. A grandfathered health plan must disclose in its plan materials whether it considers itself a grandfathered plan and must advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

Grievance . A complaint that a covered individual communicates to his or her health insurer or plan.

------ H ------

HDHP . See High Deductible Health Plan.

Health Flexible Spending Account (HFSA) . An account that an eligible employee elects through his or her employer to pay for many out-of-pocket medical expenses with tax-free dollars. Examples of eligible medical expenses include co-payments and deductibles, qualified prescription and over-the counter drugs, and medical supplies and devices. The employee decides how much of his or her pre-tax wages he or she wants taken out of his or her paycheck and put into an HFSA. The employee does not have to pay taxes on this money. The employerqs plan sets a limit on the amount an employee can put into an HFSA each year. Beginning in 2013, that amount cannot exceed $2500. The $2500 amount will be indexed for inflation in future years.

There is no carry-over of HFSA funds. This means that HFSA funds an employee does not spend by the end of the plan year cannot be used for expenses in the next year. An exception is if the employerqs HFSA plan permits employees to use unused HFSA funds for expenses incurred during a grace period of up to 2.5 months after the end of the HFSA plan year.

Health Insurance . A contract that requires a covered individualqs health insurer to pay some or all of the individualqs health care costs in exchange for a premium.

Health Insurance Exchange . See Health Insurance Marketplace.

Health Insurance Marketplace (formerly called "Affordable Insurance Exchange," "Health Insurance Exchange,+ or %Exchange+) . The ACA requires each state to create a Health Insurance Marketplace (competitive insurance marketplace), where individuals and small employers can shop for health plans. Marketplaces will assist individuals and small businesses in comparing and purchasing qualified health plans that meet certain benefits and standards. If a state decides not to establish a Marketplace, the federal government will establish a Marketplace in that state.

Health Insurance Portability and Accountability Act (HIPAA) . A federal law enacted in 1996 that improves the portability and continuity of health coverage; reduces health care fraud and abuse; mandates standards for health care information on electronic billing and other processes; and requires the protection and confidential handling of protected health information.

Health Maintenance Organization (HMO) . A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally will not cover out-of-network care except in an emergency. An HMO may require an individual to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Health Reimbursement Account (HRA) (also called %Health Reimbursement Arrangement+) . An employer-funded group health plan from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. At the employerqs discretion, unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account.

Guidance suggests that integrated HRAs may not be subject to the ACA prohibition on applying annual dollar limits to essential health benefits if offered in conjunction with a health plan that otherwise satisfies the ACAqs requirements and the HRA option is offered only to employees eligible to participate in that plan. In addition, it appears that HRAs used by employees only for payment of expenses for non-essential health benefits and HRAs that are offered only to retirees may continue to be permitted under the ACA.

Health Savings Account (HSA) . A medical savings account available to taxpayers who are enrolled in a qualified high deductible health plan. The funds contributed to the account are not subject to federal income tax at the time of deposit.

Funds must be used to pay for qualified medical expenses. Unlike a Health Flexible Spending Account, funds roll over year-to-year if an individual does not spend them.

Health Status . Refers to an individualqs medical conditions (both physical and mental health), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

HFSA . See Health Flexible Spending Account.

High-Cost Excise Tax (also called the %Cadillac Tax+) . Under the ACA, starting in 2018, a 40% excise tax will be assessed on employer-sponsored health coverage with values exceeding a certain threshold. The thresholds are $10,200 for individual coverage and $27,500 for family coverage (indexed to inflation). The excise tax will be assessed on the amount that exceeds the threshold, not on the whole value of the coverage. This tax is intended to encourage streamlining of health plans to make premiums more affordable.

High Deductible Health Plan (HDHP) . An HDHP is a health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses. HDHP qualifying deductibles and annual out-of-pocket-expenses are indexed for inflation on an annual basis.

HIPAA . See Health Insurance Portability and Accountability Act.

HMO . See Health Maintenance Organization.

HRA . See Health Reimbursement Account.

HSA . See Health Savings Account.

------ I ------

Individual Health Insurance Policy . Policies for people that are not connected to employment-based coverage. Individual health insurance policies are regulated under state law.

Individual Mandate (also called %Individual Responsibility) . Starting in 2014, the ACA requires most individuals to enroll in health coverage that meets basic minimum standards or pay a penalty.

In-Network Co-insurance . The percent (for example, 20%) a covered individual pays of the allowed amount for covered health care services to providers who contract with his or her health insurer or plan. In-network co-insurance usually costs a covered individual less than out-of-network co-insurance.

In-Network Co-payment . A fixed amount (for example, $15) a covered individual pays for covered health care services to providers who contract with his or her health insurer or plan. In-network co-payments usually are less than out-of-network co-payments.

------ L ------

Lifetime Limit . A cap on the total lifetime benefits an insurer or plan will pay for all eligible medical expenses that an individual incurs while covered under the insurance policy or plan. An insurer or plan may impose a total lifetime dollar limit on benefits (like a $2 million lifetime cap) or limits on specific benefits (like a $200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance policy or plan will no longer pay benefits. The ACA prohibits lifetime dollar limits on essential health benefits.

------ M ------

MEC . See Minimum Essential Coverage.

Medicaid . A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state by state.

Medical Loss Ratio (MLR) - A basic financial measurement used in the ACA to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has an MLR of 80%. An MLR of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The ACA sets minimum MLRs for different markets, as do some state laws.

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

Medicare . A Federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called %ESRD+).

Medicare Advantage (Medicare Part C) . A type of Medicare health plan offered by a private company that contracts with Medicare to provide all Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If an individual is enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are nor paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Hospital Insurance Tax . A tax under the Federal Insurance Contributions Act (FICA) that is a United States payroll tax imposed by the Federal government on both employees and employers to fund Medicare.

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

Minimum Essential Coverage (MEC) . The type of coverage an individual needs to have to meet the individual mandate requirement under the ACA. This includes individual market policies, employment-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Minimum Value (MV) . A health plan that covers at least 60% of the total allowed costs of benefits that are expected to be incurred under the plan. To determine minimum value, plans can use calculators or design-based safe harbor checklists provided by the U.S. Department of Health and Human Services, or can hire an enrolled actuary to provide an actuarial certification.

MLR . See Medical Loss Ratio.

MV . See Minimum Value.

------ N ------

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

New Plan . As used in connection with the ACA, a health plan that is not a grandfathered health plan and therefore subject to all of the reforms in the ACA.

In the individual health insurance market, a plan that an individual is purchasing for the first time will generally be a new plan.

With respect to group health coverage, a plan that an employer is offering for the first time will generally be a new plan. New employees and new family members may be added to existing grandfathered group plans . so a plan that is new to an employee and the employeeqs family may still be a grandfathered plan.

For both individual and group coverage, a plan that loses its grandfathered status will be considered a new plan. A plan loses its grandfathered status when it makes significant changes to the plan, such as reducing benefits or increasing cost sharing for enrollees.

A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

Nondiscrimination . A HIPAA requirement that prohibits employment-based coverage from discriminating based on health status. Coverage under employment-based plans cannot be denied or restricted. An individual also cannot be charged more because of his or her health status. Employment-based plans can restrict coverage based on other factors (such as part-time employment) that are not related to health status.

Non-Preferred Provider . A provider who does not have a contract with a health insurer or plan to provide services to covered individuals. Covered individuals must generally pay more to see a non-preferred provider. The policy or plan should be reviewed to see if covered individuals can go to all providers who have contracted with the insurer or plan, or if the insurer or plan has a %tiered+ network and covered individuals must pay extra to see some providers.

------ O ------

OOP (See Out-of-Pocket Limit)

Open Enrollment Period . The period of time set up to allow an individual to choose from available plans, usually once a year.

Out-of-Network Co-insurance . The percent (for example, 40%) a covered individual pays of the allowed amount for covered health care services to providers who do not contract with the covered individualqs health insurer or plan. Out-of-network co-insurance usually costs an individual more than in-network co-insurance.

Out-of-Network Co-payment . A fixed amount (for example, $30) a covered individual pays for covered health care services from providers who do not contract with the covered individualqs health insurer or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit (OOP) . The most a covered individual pays during a policy or plan coverage period (usually a year) before the individualqs health insurance or plan begins to pay 100% of the allowed amount. Beginning in 2014, non-grandfathered individual, small group, large group, and self-insured health plans must limit the annual OOP (deductible, co-insurance, and co-payments for in-network providers) to the amounts allowed for HDHPs. This limit does not include premiums, balance-billed charges, health care the health insurance or plan does not cover, or cost sharing for out-of-network providers.

------ P ------

Patient-Centered Outcomes Research (PCORI) Fee (also called %Comparative Effectiveness Research (CER) Fee+) . A new fee on plan sponsors and insurers providing accident or health coverage (grandfathered and non-grandfathered) used to fund the Patient-Centered Outcomes Research Institute (PCORI). PCORI will conduct research that compares different medical treatments and interventions to provide evidence on which strategies are most effective in different populations and situations. For the first year (plan/policy years ending on/after October 1, 2012 and before October 1, 2013), the fee is $1 per covered individual per year. This increases in the second year (plan/policy years ending on/after October 1, 2013 and before October 1, 2014) to $2 per covered individual. The fee is then indexed to national health expenditures until 2019, when it will no longer be collected.

Pay or Play Mandate . See Employer Shared Responsibility.

Plan Year or Policy Year . A consecutive 12-month period of benefits coverage under a health plan or insurance policy. This 12-month period may not be the same as the calendar year. The plan or policy documents stipulate the plan or policy year.

Point-of-Service Plan (POS) Plan . A type of plan in which a covered individual pays less if he or she uses doctors, hospitals, and other health care providers that belong to the planqs network. POS plans may require the individual to get a referral from his or her primary care doctor in order to see a specialist.

POS Plan . See Point of Service Plan.

PPO . See Preferred Provider Organization.

Preauthorization (sometimes called %prior authorization,+ %prior approval,+ or %precertification+) - A decision by an individualqs health insurer or plan that a health care service or supply is medically necessary and appropriate. The individualqs health insurer or plan may require preauthorization for certain services before the individual receives them, except in an emergency. Preauthorization is not a promise that an individualqs health insurance or plan will cover the cost.

Pre-Existing Condition Exclusion Period . The time period during which a health plan will not pay for care relating to a pre-existing medical condition. Under an employment-based plan, this cannot exceed 12 months for an individual who enrolls as soon as possible or 18 months for an individual who enrolls later. Beginning in 2014, the ACA prohibits pre-existing condition exclusion periods from being applied to any enrollees.

Pre-Existing Condition Insurance Plan (PCIP) . A new program that provides a health coverage option for individuals who have been denied coverage due to a pre-existing condition and have been uninsured for at least six months. This program will provide coverage until 2014, when coverage will be available through Health Insurance Marketplaces.

Preferred Provider . A provider who has a contract with a covered individualqs health insurer or plan to provide services at a discount. The policy or plan documentation should indicate if covered individuals can see all preferred providers or if the policy or plan has a %tiered+ network and covered individuals must pay extra to see some providers. The health insurance or plan may have preferred providers who are also %participating+ providers. Participating providers also contract with the health insurer or plan, but the discount may not be as great, and covered individuals may have to pay more.

Preferred Provider Organization (PPO) . A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. A covered individual pays less if he or she uses providers that belong to the planqs network. Covered individuals can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium . The amount that must be paid for an individualqs health insurance or plan coverage.

Premium Subsidy (Subsidy) . A fixed amount of money or a designated percentage of the premium cost that is provided as a tax credit to help low income individual purchase health coverage through the Health Insurance Marketplaces.

Preventive Services . Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Under the ACA, non-grandfathered health plans must cover certain preventive services obtained from in-network providers without cost sharing (deductibles, co-insurance, or co-payments).

Provider . A physician (M.D. . Medical Doctor or D.O. . Doctor of Osteopathic Medicine), health care professional, or health care facility licensed, certified or accredited as required by state law.

------ Q ------

Qualified Health Plan - Under the ACA, starting in 2014, an insurance plan that is certified by a Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, co-payments, and out-of-pocket limits), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

------ R ------

Rate Review . A process that allows state insurance departments to review rate increases before insurance companies can apply them to policyholders.

Reinsurance . A reimbursement system that protects insurers from very high claims. It usually involves a third party paying part of an insurerqs claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.

Rescission . The retroactive cancellation of health coverage. The ACA prohibits rescission except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Risk Adjustment . A statistical process that takes into account the underlying health status and health spending of the enrollees in a health plan when looking at their health care outcomes or health care costs.

------ S ------

SBC . See Summary of Benefits and Coverage.

Self-Insured Plan (also called a Self-Funded Plan) . A type of plan where the employer collects premiums from enrollees and takes on the responsibility of paying employeesq and dependentsq medical claims. These employers can contract for administrative services such as enrollment, claims processing, and provider networks with a third party administrator, or they can self-administer the plan.

Small Business Health Options Program (SHOP) . The ACA requires states to create a Small Business Health Options Program (SHOP) designed to help small employers access affordable insurance for their employees. The law also allows states to combine their SHOP with their Health Insurance Marketplace for individual consumers. The U.S. Department of Health and Human Services has proposed that in 2014, a SHOP may elect to have businesses choose one plan to offer employees, and in 2015 employees will be able to choose from the full range of plans in the Marketplace.

Small Business Tax Credit . A tax credit available to small businesses that offer health coverage to their workers. To qualify, a small employer must have 25 or fewer full-time workers, pay average annual wages under $50,000 per full-time worker, and pay at least half of the cost of single health coverage. Tax credits vary with the contribution, size, and tax status of the small employer.

Special Enrollment Period . A time outside of the open enrollment period during which an individual and his or her eligible family members have a right to sign up for employment-based health coverage. Employment-based plans must provide a special enrollment period of at least 30 days following certain life events that involve a change in family status (for example, marriage or birth or adoption of a child) or loss of other employment-based health coverage.

State Continuation Coverage . A state-based requirement similar to COBRA that applies to group health insurance policies of employers with fewer than 20 employees. In some states, state continuation coverage rules also apply to larger group insurance policies and add to COBRA protections.

Subsidy . See Premium Subsidy.

Summary of Benefits and Coverage (SBC) . The ACA requires group health plans and health insurers to provide access to a brief, standardized document that describes the benefits and coverage under the applicable health plan so that those covered can compare plan benefits among and between other plans and insurers.

------ T ------

Transitional Reinsurance Program Fee . A fee used to fund a transitional reinsurance program, established by the ACA to stabilize the individual health insurance market during the first three years of Health Insurance Marketplace operation (2014 . 2016). The program will collect contributions from insurers and self-insured plan sponsors providing major medical coverage. The U.S. Department of Health and Human Services has estimated that the fee assessed in 2014 will be $63 for each covered individual.

------ U ------

UCR . See Usual, Customary, and Reasonable.

Uniform Glossary . In conjunction with the Summary of Benefits and Coverage, the ACA requires group health plans and health insurers to provide standard definitions of terms commonly used in health insurance coverage.

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

------ W ------

Waiting Period (Employment-Based Coverage) . The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under an employment-based health plan. Beginning in 2014, the ACA prohibits group health plans from applying a waiting period that exceeds 90 days.