

Quick-Start Guide to the Affordable Care Act

**2015 Health Insurance Marketplace
Open Enrollment Period**

UPMC HEALTH PLAN

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Network choices: That's the advantage of UPMC Advantage

Health care reform is in full swing, and individuals under the age of 65 are now able to shop, compare, and purchase health insurance coverage. UPMC *Advantage* plans for individuals and families offers three distinct network choices to meet your unique needs. All UPMC *Advantage* plans have in-network access to UPMC providers and UPMC-owned facilities, and some offer access to independent providers as well. Choose your network, then choose your plan. **It's that easy.**

UPMC Partner Network (EPO)

- Offered to people who live in Allegheny or Erie counties.
- Includes all UPMC providers and UPMC-owned facilities.
- In Erie, some independent providers and facilities are included, such as Cory Memorial Hospital.
- Members can receive care from any UPMC provider or UPMC-owned facility in the 28-county service area.

UPMC Select Network (EPO)

- Offered to people who live in the five-county region of Allegheny, Beaver, Butler, Washington, and Westmoreland.
- Includes all UPMC providers and UPMC-owned facilities.
- **Also includes our community partners:** Butler Memorial Hospital, Excelsa Health System, Heritage Valley Health System, Monongahela Valley Hospital, and Washington Health System.

UPMC Premium Network (PPO)

- Offered to people who live in the entire 29-county service area.
- Includes all UPMC providers and UPMC-owned facilities, along with many independent providers and facilities.
- Members have the option to receive care outside of the network, but will pay a greater share of the cost if they do.

Contact us for more information about UPMC *Advantage* or to enroll in health insurance coverage.

Call: 1-877-563-0292

Visit: www.upmchealthplan.com/coverage

UPMC HEALTH PLAN
Marketplace

Introduction

When President Obama signed the Affordable Care Act (ACA) into law several years ago, *The New York Times* called it the “most expansive social legislation enacted in decades.”

Some celebrated on that day, March 23, 2010. Others raised their voices to protest parts of the new law.

Years later, one thing is certain: Health care in the United States has changed forever. Many of the biggest changes from the ACA took effect on January 1, 2014.

The ACA is a document that includes almost 1,000 pages of legal terms, new law, and changes to existing laws. With this **Quick-Start Guide to the ACA**, UPMC Health Plan is providing you an easy way to look at the law. A way that removes confusion. A way that speaks to you in clear terms.

We encourage you to spend some time with this information. You will be surprised at how simple many of the ideas in the ACA really are.

Read on to learn more about health care reform. And don’t forget to look at the **20 Fast Facts** in the back of this Guide for more detailed information.

Why should you care about health care reform?

One simple answer is this: If you live in the United States, it will affect you.

Today, you may already have good health coverage from your employer or through an individual policy, and that’s great – many people are able to keep the coverage they have. But even if you’ve had the same coverage for a long time, you probably have already been affected by the ACA. Now your children can be covered on your plan until they reach age 26. Now you are getting plain-language explanations of your coverage. Now you can get certain preventive services at no cost, guaranteed.* These things all happened because of the ACA.

The changes have come fast. And they will continue to come.

Starting in October 2013, some people began buying their health coverage through a new Health Insurance Marketplace in each state. Now you can be fined if you don’t have health coverage. In 2015, some employers will be fined if they don’t offer solid health coverage that their employees can afford. It may sound like a lot of new and confusing rules, but all of this mandating, fining, and requiring has a purpose.

The piston of a car is useless if it’s not connected to other parts. But it is powerful when it is part of an engine. In the same way, the ACA’s parts are all designed to work together.

Keep reading. We’ll explain the parts of the ACA. And we’ll explain how they work together to provide more coverage to more people.

**Grandfathered health plans may be exempt from providing preventive services at no cost. Grandfathered health plans are those that existed on or before March 23, 2010, and have met specific guidelines to remain exempt from certain aspects of the ACA.*

FAST FACTS

#1 – Dependents now enjoy coverage until they turn 26 years old.

Learn more on page 12.

#2 – Most group and individual health plans are required to cover certain preventive health services at no cost to their members.

Learn more on page 12.

What's so affordable about all this?

Drugs and medical care can be expensive. But that's not what the ACA means by "affordable."

Within the ACA, "affordable" means balanced. The newly created system protects against unexpected cost spikes. In other words, your costs might be different from your neighbor's, but nobody will have to pay 10 times more than someone else for the same coverage.

Here is a quick look at how it works:

Some people get tax credits to help pay for their health coverage. Some other people and companies may have to pay fines, fees, and taxes that help fund those tax credits. This is designed to create financial balance.

There is one other important part of achieving balance. Everyone will have a right to buy health coverage, and no one can be turned down because of an existing illness. In fact, people who live in the same area will pay about the same as others their age, no matter what their health needs are. The law requires almost everyone to have health coverage, which helps people stay healthy, and evenly spreads coverage costs.

It's easy, right? Everyone has coverage, and those who need it can get financial help.

That is the goal of the ACA. It intends to ensure that all are covered. And it intends to make sure everyone can afford their coverage.

FAST FACTS

#3 – Payment risk is balanced throughout the community by setting average premiums based on a large group of people instead of per individual.
Learn more on page 13.

#4 – Even if you are sick, you can get health insurance ... guaranteed.
Learn more on page 14.

Putting oil in the well-oiled machine.

"Community rating" and "guaranteed issue."

Insurance talk. Ugh! But don't stop reading. These are important ideas. And, as promised, we'll show you how simple they really are.

Before the ACA, most insurers were not obligated to sell coverage to someone who had an existing health condition. If they did cover them, the insurer could charge higher premiums to offset treatment costs.

Community rating is required by the ACA. It is a term that means this:

Everyone is included in a big group. An insurer creates a premium based on how much it will cost, on average, to cover that group. In most cases, unhealthy people will pay the group average premium and so will healthy people.

Now, let's look at guaranteed issue, also a part of the ACA.

Under the ACA, insurers have to offer coverage to anyone who wants it – guaranteed. Consumers do have to meet a few guidelines. If you live in Idaho, for example, you're not eligible for coverage offered only in Pennsylvania. And you may only be able to purchase coverage during certain times of the year.

If you want to buy health coverage, you can get it. Your health coverage is also guaranteed to renew for as long as you want it (subject to availability). Guaranteed issue is really that easy.

Together, community rating (similar premiums for all) and guaranteed issue (everybody can get coverage) work together to provide coverage at affordable rates. That is a big part of making the ACA work. It's the oil in the engine.

I don't have a lot of money. Now what?

If you are not already well covered, you can get insurance through a **Health Insurance Marketplace**.

People who qualify – and many people do – can get financial assistance, which helps them buy coverage or reduce out-of-pocket costs.

Advance Premium Tax Credits. People with incomes up to about \$95,400 (for a family of four) may receive financial assistance in the form of tax credits. These are paid to your health insurer to lower your premiums. You can use the credits when buying health coverage to reduce your costs. Just remember, you need to claim them on your tax return!

Cost-Sharing. Health insurers use this term to mean you have to pay certain costs out of your own pocket when you get care. This includes things like “copayments,” “deductibles,” and “coinsurance.”

The ACA addresses cost-sharing in three ways:

- The ACA puts new limits on cost-sharing for everyone, regardless of income. Once people reach the limit under their plan, they no longer have to pay cost-sharing charges when they get care.
- Families with incomes up to about \$59,000 (for a family of four) will have lower total cost-sharing levels.
- For families with a household income up to about \$59,000 (for a family of four), the ACA may also reduce the amount of cost-sharing that they pay each time they get care. For example, a \$20 copayment might be reduced to \$10.

Once again ... easy. If you buy coverage through the Marketplace, any financial assistance you qualify for can be automatically applied.

Just remember to claim any tax credits on your annual tax return.

Now, let's talk about the Marketplace.

FAST FACTS

#5 – Financial assistance in the form of tax credits can reduce health insurance premium costs.

Learn more on page 15.

#6 – The out-of-pocket cost you pay for health services is limited.

Learn more on page 17.

#7 – The Health Insurance Marketplace provides a unique online experience for comparing plans and purchasing health care coverage.

Learn more on page 17.

Let's go shopping!

Buying health coverage is not as fun as buying a new pair of sneakers. But it's just as easy on the new Health Insurance Marketplace.

Each state will have a Marketplace where individuals and families can shop for, compare, and buy health coverage. But you won't benefit from it if you are already well-covered at work or are eligible for Medicaid, Medicare, or, in some cases, Children's Health Insurance Plan (CHIP).

Those who do use it will find many plans offered by many insurers. Sound like it could get confusing?

Well, the ACA makes it simple. In the Marketplace, every insurer has to design health coverage plans to meet specific requirements and present them in the same way.

Plan Coverage Categories:	
▪ Platinum plan	– pays about 90% of your covered costs.
▪ Gold plan	– pays about 80% of your covered costs.
▪ Silver plan	– pays about 70% of your covered costs.
▪ Bronze plan	– pays about 60% of your covered costs.

While Platinum plans cover more of your costs, they will also have higher monthly premiums than the other plans. When comparing plans, think about the balance between the monthly premium and the level of coverage you need.

If coverage plans are all presented the same way, does it matter which insurer I choose?

Yes. While many financial aspects of health coverage will be similar for each insurer, other things will be different.

UPMC Health Plan, for example, has a strong network of hospitals and doctors, anchored by UPMC's world-class medical facilities. We also have excellent chronic disease care programs and wellness programs. Be sure to look for those resources, and others, when you shop.

Open enrollment for 2015 will start on November 15, 2014, and end on February 15, 2015.

Many people will buy online. They will also be able to buy coverage over the phone, by mail, or even in person.

Access to the Marketplace is available through www.upmchealthplan.com and www.healthcare.gov.

FAST FACT

#8 – Actuarial value can help consumers quickly pick a cost level they are comfortable with.
Learn more on page 19.

Actually ... there is math involved.

The ACA and insurers use the term **actuarial value** when talking about coverage plans. It may sound like insurance jargon. But Marketplace plans rely on this concept.

Actuarial value simply means the average share of costs that are covered by your insurer when you get covered benefits.

So, when we said insurers will pay about 70 percent under a Silver plan, that reflects an actuarial value of 70 percent.

There is a lot of math behind this. But you don't need to know the details. Just know that you will pay, for example, about 30 percent of the total covered costs in a Silver plan, while the insurer picks up the remaining 70 percent of those costs. It is up to insurers to create plans that work out that way.

Some benefits are essential.

All cars are required to have seatbelts. In a similar way, the ACA requires all plans sold on the Health Insurance Marketplace to offer certain basic benefits.

We mentioned earlier that certain preventive care must be covered at no cost. In 2014, the ACA goes a step further. It sets up 10 health categories called **essential health benefits**. Plans sold on the Marketplace must offer coverage for essential health benefits and clearly indicate member cost-sharing requirements.

This takes some of the guesswork out of shopping for coverage, because any plan in the Marketplace will include coverage for essential health benefits.

The benefits, such as hospital and emergency services, are things you would expect full health coverage to include.

Again, if you shop on the Marketplace, most basic benefits will be the same between insurers. When shopping, make sure you look for plans with features that are important to you, such as in-network access to the doctors and hospitals you want to use.

Health plans sold on the Marketplace must be qualified.

Health plans that want to sell coverage on the Marketplace must be certified. Once certified, they are called **qualified health plans**.

We won't dwell on this process. But you should know that state and federal governments monitor the Marketplace, and they have rules for insurers who want to sell there.

The result is that the Marketplace will only offer approved coverage plans that come from certified insurers who meet the same important rules and guidelines. That means less confusion, less guesswork, and less time trying to compare plans. So you can easily pick the plan that's right for you.

Yes, you will probably be fined if you don't have coverage.

There are a few groups of people who will not be required to have health coverage starting in January 2014. American Indians are one example. (See **Fast Fact #11** on page 23 for additional examples.)

If you are not a member of one of those groups, you are required to have coverage. If you do not have health coverage, you will have to pay a fine.

The ACA calls this the **individual responsibility requirement**, or **individual mandate**.

The ACA uses the fine to encourage everyone – even very healthy people – to get and maintain health coverage. People who don't have health coverage must pay either a flat amount or a percentage of their annual income – whichever is greater. The fine will grow over time. Having health coverage is a good thing, and this fine is just one more good reason to get coverage for you and your family.

If you already have health coverage, there is no need to worry. Coverage through programs like Medicare, Medicaid, CHIP, and military TRICARE all count. So do most plans that you buy yourself or that you get from your employer. If you don't have coverage now, or if you just need to find a new plan for January 2015, the Marketplace may offer financial assistance to help reduce your health coverage costs.

FAST FACTS

#9 – Essential health benefits ensure that most Americans will have affordable coverage for many important health services.

Learn more on page 20.

#10 – Qualified health plans must prove they meet a set of requirements before becoming certified.

Learn more on page 21.

#11 – Individuals must have coverage to be responsible for their own health care.

Learn more on page 22.

FAST FACTS

#12 – Employers are sharing more responsibility for providing their workers with affordable coverage.

Learn more on page 24.

#13 – The IRS will need to collect basic information about workers who have health coverage.

Learn more on page 25.

#14 – Employers must provide the IRS with cost information on the plans they offer their employees.

Learn more on page 26.

Do you know how your employer and insurer are adjusting to health care reform?

There are many responsibilities for employers and insurers related to health care reform. Right after the ACA was passed, businesses and health insurers started making changes and planning for other changes in the future.

Changes and preparations include:

- Preparing to give more information about you to the Internal Revenue Service (IRS)
- Giving you easy-to-understand coverage information
- Preparing for new taxes and fees
- Building health coverage that follows new rules

On top of all that, many employers will soon be required to offer health coverage to their employees. Beginning January 1, 2015, the ACA requires large employers to offer coverage to 70 percent of full time employees. Large employers who do not provide the coverage will be fined.

In 2015, the fines will affect employers who have 100 or more full-time equivalent employees.

Those larger employers must pass several tests to avoid being fined. For example, the plans they offer must have an actuarial value of at least 60 percent. The employee share of premiums also has to be affordable – no more than 9.5 percent of an employee's household income.

So, there are three important points:

- Small companies are not subject to the fines.
- Most larger companies already offer good insurance benefits.
- If you work for a larger employer that doesn't offer coverage or if your share of premiums is unaffordable, you may be eligible for financial assistance to buy coverage on the Marketplace. Your approval for a Marketplace plan may trigger a fine for your employer, starting in 2015.

The IRS will get more information about you.

Someone has to make sure everyone is following all the new ACA rules. Part of that job was assigned to the Internal Revenue Service (IRS).

Starting in January 2015, health insurers will be required to tell the IRS who has coverage. And larger businesses must tell the IRS about health coverage they provide to employees. This information will be used to help decide who has to pay a fine and who is likely eligible for financial assistance to buy coverage on the Marketplace.

Remember:

- Starting in 2015, businesses may be fined for not providing full, affordable health coverage.
- Starting in 2014, individuals may be fined for not having health coverage.

Another reminder about the IRS: If you receive a premium tax credit through the Marketplace, you must claim it on your annual tax return.

The W-2 tax form that your employer provides each year may also change. Many large employers may put costs associated with your health coverage on your W-2.

A few other rules for your employer...

Your employer has many new rules it must follow under the ACA.

Here are a few you may be interested in:

New information for you. Most employers must give employees a notice about the Marketplace, and explain why they may or may not be eligible to buy a Marketplace plan. They will also tell employees that financial assistance is available through the Marketplace, and may give them a worksheet to help determine whether they are eligible.

Automatic enrollment. Large employers eventually will be required to auto-enroll you in health coverage. That means if you do nothing, your company will enroll you in health coverage. They also must give you a chance to refuse that coverage. The federal government is still creating rules for this provision.

Taxes and fees. Many employers will be paying new taxes and fees created by the ACA. We mention them here because they are part of the financial balance. Money from taxes and fees will be used to help stabilize cost spikes and make coverage affordable for more people.

Waiting periods. There is often a waiting period for people who apply to enroll in their employer's health coverage. The ACA requires that the waiting period be no longer than 90 days. One exception is employers may offer a one-month orientation period before the 90-day waiting period begins.

Your insurer is making changes, too.

The ACA has many requirements for insurers. Some of those new rules will affect you.

Insurer spending. The ACA requires health insurers to spend a certain percent of their premiums on their members' health care and quality improvement. If they don't, they will owe employers or members a premium rebate. This is judged by something called a **medical loss ratio** (the ratio: health care spending vs. spending on company operations).

Rate reviews. State and federal governments are now required to review all large rate increase requests from health insurers. In most cases, states will decide if the requested rates are reasonable. They will also make rate information available to the public.

Coverage information. Insurers must give you a uniform **Summary of Benefits and Coverage**. This is just a plain-language summary of health coverage.

FAST FACTS

#15 – Employers must give employees information about the Health Insurance Marketplace.

Learn more on page 27.

#16 – Auto-enrollment of employees in health coverage will become a requirement for large employers.

Learn more on page 27.

#17 – The ACA includes taxes and fees for health insurers, to aid health care research efforts and manage financial risk.

Learn more on page 28.

#18 – Waiting periods of more than 90 days are not allowed for new employees to become eligible to enroll in coverage from their employer (with the one exception noted under).

Learn more on page 29.

#19 – The ACA encourages insurers to efficiently use the money they collect from premiums.

Learn more on page 30.

#20 – A streamlined Summary of Benefits and Coverage statement debuted with the ACA.

Learn more on page 31.

Summary

We hope you have seen how everyone – even you – is affected by the many changes of health care reform.

The ACA was created to make U.S. health coverage more affordable and easier to use. Over the past several years, thousands of people have been working behind the scenes to help make health care reform a success.

Meanwhile, UPMC Health Plan is here to help you navigate the new system.

Our website, **www.upmchealthplan.com/reform**, has additional information about the ACA. It also provides a way to buy coverage that meets ACA guidelines.

If you have questions about health care reform or want to speak to someone about new ways to buy health coverage for yourself and your family, **call us at 1-855-230-8762, Monday through Friday from 8 a.m. to 5 p.m.**

Additional contact information at UPMC Health Plan for individuals and families, employers, providers, producers, and navigators is listed on page 34 of this booklet.

20 Affordable Care Act Fast Facts

Read on for more details.

1 Coverage for Dependents

When the Affordable Care Act was passed in 2010, there was widespread relief among parents and their college-aged children.

Before the ACA, many health plans ended coverage for children when they graduated from college or reached 22 years of age.

The ACA made it mandatory for health plans that offer dependent coverage to cover children under a parent's health plan, until they reach age 26.

Covered children under age 26 cannot be denied benefits under a parent's plan based on:

- Where they live
- Whether they are in school
- Whether they are married

Children who are covered under this provision cannot be treated differently. They must be offered all of the benefit packages normally available to dependents. They also cannot be charged more than what is normally charged for dependent coverage.

While some health plans' dependent coverage will end on the dependent's 26th birthday, other health plans may cover dependents for a period beyond their 26th birthday.

2 Preventive Services Now Covered

The Affordable Care Act requires most group and individual plans to cover certain preventive health care services at no cost to members. The no-cost provision is true only when the services are received from in-network primary care providers.

Preventive services include:

- Many vaccinations
- Blood pressure screenings
- Certain cancer screenings
- Well-baby visits

For most people, in-network preventive services will be available at no cost.

The U.S. Department of Health and Human Services provides a list of preventive services covered under the ACA. This list can be found at www.healthcare.gov.

Not all preventive services are recommended for every patient. Also, some tests or screenings may not be recommended every year. Patients should talk with their doctor about the preventive services that they may need.

Grandfathered health plans are exempt from this requirement.*

Contraceptives

Preventive services coverage includes certain contraceptives. However, certain nonprofit "Religious Employers," such as churches, are not required to cover contraceptives as a preventive service. Other employers who have a religious objection to providing coverage for contraceptives might also be permitted to exclude this coverage. In some cases, this coverage may be provided separately to an employer's workers by the employer's insurer.

Note: *Because many contraceptives are prescription drugs, coverage may be subject to rules or limits that do not apply to other preventive services.*

**Grandfathered health plans are those that existed on or before March 23, 2010, and have met specific guidelines to remain exempt from certain aspects of the ACA.*

3 Creating Financial Balance

Sarah is 39 years old and suffers from the chronic illness emphysema. She makes a lot of trips to the doctor and the drug store.

Sam is a 37-year-old jogger who never goes to the doctor.

Who will pay a higher premium for health coverage?

It's a trick question. Under the Affordable Care Act (ACA), they will pay about the same.

The ACA will make health coverage more affordable for people who have an existing illness or chronic health condition.

The ACA adopted a system that encourages standard premiums within a group of people based on the average cost of providing coverage. This approach is called **community rating**.

Community rating sets base premiums on the average cost of coverage among a large group of people, rather than the actual cost of covering each individual.

To make sure the average premiums cover the costs of providing care for anyone in the group, the ACA requires everyone, even the very healthy, to have health coverage.

In the example at the top of this page, Sam, Sarah, and others like them will all share the responsibility of spreading the cost of health care more evenly among the group. Sarah will benefit from affordable rates now. Sam may benefit more fully in the future when he uses his benefits more often.

Putting Community Rating to Work

Under the ACA, health insurance sold to individuals and companies in Pennsylvania with fewer than 50 workers will use community rating.

Insurers cannot charge higher premiums for those in poor health. However, under community rating, insurers can offer different premiums for the following reasons:

- Family size
- Age
- Geographic location
- Tobacco use

4 Health Coverage Guaranteed

The Affordable Care Act can be hard to understand. But one part is easy. As of January 1, 2014, you cannot be denied health coverage because of an existing illness or health condition.

Insurers also cannot refuse to renew your coverage because you are sick.

The technical term for this is **guaranteed issue**. It means people with pre-existing health conditions cannot be denied coverage.*

Previously, some insurers could deny coverage to people who might need to use a lot of medical services. Now, those people can get the same coverage everyone else gets - and also be guaranteed to renew their coverage if they want to (subject to market availability).

The ACA encourages everyone to share the cost and responsibility of having coverage so that we can all count on the system when we need it. Since no one can be denied health coverage because of a health condition, the ACA mandates that nearly everyone in the country – young, old, healthy, and not so healthy – get and keep health insurance. This is called **individual shared responsibility**, or the **individual mandate**.

Guaranteed issue and the individual mandate work together to ensure premiums are more evenly balanced for everyone. This balance is what lets **community rating** work.



While insurers cannot deny health coverage because of an existing illness or health condition, they can still deny coverage for practical reasons, such as:

- The applicant does not live in the insurer’s service area.
- The applicant does not qualify for the coverage (for example, an employer with five workers cannot buy health coverage designed for employers with more than 50 workers).

Insurers cannot deny coverage because of pre-existing health conditions.

**Guaranteed issue does not apply to grandfathered health coverage for individuals. Grandfathered health plans are those that existed on or before March 23, 2010, and have met specific guidelines to remain exempt from certain aspects of the ACA.*

5 Advance Premium Tax Credits

The Affordable Care Act provides a way for some consumers to lower their premiums for health coverage.

An Advance Premium Tax Credit allows low- and moderate-income people to reduce premiums in one of these two ways:

- Getting advance payments sent monthly to the insurer. These payments will be credits applied to your premium.
- Receiving a year-end rebate for premiums paid.

The credits started in 2014. They are available for individuals who buy health coverage through a Health Insurance Marketplace (**see Fast Fact #7**).

When you are shopping for coverage through the Marketplace, you can see your available tax credit after you complete an application. Then, you can decide how much of the credit you want to use to reduce your health coverage premiums.

If the tax credit is used immediately, it is sent directly to your insurance company to reduce your monthly premiums. If you don't use your tax credit right away, or if you only use part of your credit, you can receive the remaining value of the credit as a refund when you file your federal tax return.

Because this financial help is a tax credit, it must be claimed on a tax return.

Eligibility

Advance Premium Tax Credits are available to low- and middle-income U.S. citizens and legal immigrants who are not eligible for other coverage, or who cannot afford coverage offered by their employer. The tax credit is based on factors such as household income and the percentage of that income spent on health coverage.

If your household income is no more than about \$46,000 for an individual or \$95,400 for a family of four, you may be eligible for a tax credit.

To be eligible for an advance premium tax credit, an individual must:

- Have household income between 100% and 400% of the federal poverty level.
- Not be eligible for other **minimum essential coverage**, including:
 - Medicaid, Medicare, CHIP, or military TRICARE; or
 - Employer-sponsored coverage that provides minimum value and is affordable.
- Purchase their coverage through the Health Insurance Marketplace.

5 Advance Premium Tax Credits, cont.

Payment Levels

Advance Premium Tax Credits limit what people will be required to pay for health coverage.

*For example, those eligible for a tax credit will have their health insurance premium payments capped within this range for Silver plans:**

Individuals

- **Lowest income** – individuals with incomes at 100 percent of the federal poverty level (about \$12,000) will pay no more than 2 percent of their income in health insurance premiums, or about \$20 per month.
- **Highest income** – individuals with incomes at 400 percent of the federal poverty level (about \$46,000) will pay no more than 9.5 percent of income in health insurance premiums, or about \$375 per month.

Family of Four

- **Lowest income** – a family of four with an income at 100 percent of the federal poverty level (about \$24,000) will pay no more than 2 percent of their income in health insurance premiums.
- **Highest income** – a family of four with an income at 400 percent of the federal poverty level (about \$95,400) will have to pay no more than 9.5 percent of income in health insurance premiums.

**More generous plans with lower cost-sharing levels (such as Gold and Platinum) will have higher premiums. Individuals and families with incomes between 100 and 250 percent of the federal poverty level will be eligible for special plans with reduced cost-sharing.*

Premium tax credits will reduce health coverage costs for some people.

% Federal Poverty Level	300-400%	9.5%
	250-300%	8.0 - 9.5%
	200-250%	6.3 - 8.0%
	150-200%	5.0 - 6.3%
	133-150%	3.0 - 5.0%
	100-133%	2.0%
		Maximum % of income paid in premiums

6 Cost-Sharing Limits

The Affordable Care Act limits your out-of-pocket costs for health services. These new standard limits create stability and make it easier to compare plans from different health insurers.

Out-of-pocket costs can include copayments, coinsurance, and deductibles for medical and prescription costs. Those costs do not include the amount you pay for premiums.

*The maximum amount a plan may require people to pay out-of-pocket for their health services has the following limits for calendar year 2015:**

- \$6,600 for individual coverage
- \$13,200 for family coverage

These values will be updated by the federal government each year.

**For qualified high-deductible Health Savings Account (HSA) plans, the IRS limits out-of-pocket costs to \$6,450 per individual and \$12,900 per family.*

Limiting Your Costs Out-of-Pocket Limits*	
Single \$6,600	Family \$13,200

7 Health Insurance Marketplace

Perhaps the most talked-about part of the Affordable Care Act is the Health Insurance Marketplace.

The Marketplace is a virtual market where you can shop for, compare, and buy health coverage. There is a section for individuals and a section for small businesses. Most people will shop for coverage on the Marketplace website, but you can also speak to a Marketplace representative by phone, or even fill out a paper application and mail it in!

As an individual, you will provide some information about yourself, learn about your options, and choose a plan that is right for you. After choosing, you will be sent to the website of the insurer that issues your plan, where you can pay for the health coverage you selected.

The Marketplace in each state (every state will have one) must follow federal guidelines. Many of these guidelines help make it easier for you to compare available health plans.

The Marketplace seems easy, right?

As with many things that look easy, there is a lot going on behind the scenes. Let's review a few of those things.

7 Health Insurance Marketplace, cont.

Financial Assistance

Financial assistance, like Advance Premium Tax Credits and cost-share reduction subsidies, are available through the Marketplace for people with low or moderate incomes. These types of financial assistance are based on how close your family income is to the federal poverty level.

Qualified Health Plan

Coverage sold on the Marketplace must be qualified. Being qualified means the plan has been reviewed by the Marketplace and that it meets ACA guidelines.

Comparing Plans

The Marketplace was created to allow consumers to compare health coverage from many insurers. All plans must follow the same rules. For example, all full-coverage plans will pay at least 60 percent of your average costs for covered health services. And they will all cover the same essential health benefits.

Open Enrollment

Customers will use the Marketplace to buy health coverage during the 2015 open enrollment period, which begins on November 15, 2014, and ends on February 15, 2015.

Do You Have to Use it?

No. You can skip the Marketplace and buy health coverage directly from an insurer. In fact, all of the plans available on the Marketplace are also available directly from the insurers that sell them. Also, if you have adequate health coverage through an employer or government program, you can most likely continue with that coverage.

Organization

Each state will have a Marketplace where uninsured people can purchase health coverage. Depending on which state you live in, the Marketplace will be run by either the state government or the federal government.

Navigators

If you need help understanding health insurance and the Marketplace, Navigators will be available to help. Navigators are people or organizations in your region that can offer free, unbiased information, answer questions, and provide clear explanations.

How Do I Find the Marketplace?

You can start with your local health insurance company. UPMC Health Plan offers access to the Health Insurance Marketplace on our website at www.upmchealthplan.com.

The ACA requires health insurers to offer standard benefits on the Health Insurance Marketplace. You can compare many plans. The online site makes it easy to select and pay for health coverage.

8 Actuarial Value

Actuarial value. Sounds confusing, but read on – we’ll make it easy!

In its simplest form, actuarial value means the percentage of your covered health care costs that your health plan will pay for (on average).

Why You Should Care About Actuarial Value

The Affordable Care Act created four health plan categories. These are Bronze, Silver, Gold, and Platinum. Plans on the new Health Insurance Marketplace will be labeled with one of these categories.

If you are shopping for insurance, you might be inclined to pick your favorite metal. Be careful. These metals indicate the actuarial value of your plan, so there are important costs to think about when you are shopping.

In general, the share of covered health care costs paid by the plans in each category are:

- **Bronze – 60%**
- **Silver – 70%**
- **Gold – 80%**
- **Platinum – 90%**

Note: Plans offering only catastrophic health coverage will also be available in the Health Insurance Marketplace.

There are two important things to remember:

- You will be responsible for the share, or percentage, of health care costs that your plan doesn’t pay for.
- Actuarial values are averages, so your actual costs during the year might be slightly higher or lower than the percentage that is shown.

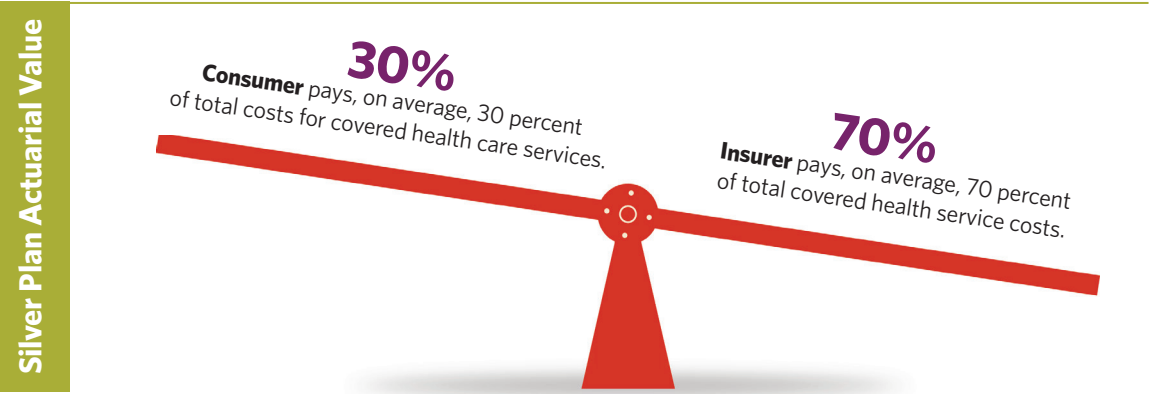
The percentages in the above list are influenced by these factors:

- Deductibles
- Coinsurance
- Copayments
- Out-of-pocket maximum

Other factors such as tax credits and cost-sharing subsidies can make the whole thing a bit messy for non-mathematicians. Just know that, on average, all Bronze plans will cover about 60 percent of your covered health care costs, all Silver plans will cover about 70 percent, and so on.

The idea behind all these metals is that consumers can quickly pick a cost level they are comfortable with ... such as Silver. *Then, knowing all Silver plans are similar in total expected out-of-pocket costs, they can make a decision based on other major concerns, such as:*

- Premiums
- Wellness programs
- Whether their doctor is in the network



9 Essential Health Benefits

The Affordable Care Act includes several things that will help people compare health plans. Among them are essential health benefits.

In its simplest form, **essential health benefits** is a list. The law provides this list of services that most plans must cover.

This is the list:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative (such as physical therapy after an injury) and habilitative (such as speech therapy not related to an injury) services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including dental and vision care

Knowing that most plans cover these services makes it easier to choose health coverage. The list represents a minimum set of health care services that most plans must cover, so you know you're getting the same basic coverage from just about any plan you choose.

In addition to comparison shopping, essential health benefits has another role to play. It ensures that most people will have affordable coverage for these services. Most plans are not allowed to limit the dollar amount they will pay for essential health benefits during a year or during the lifetime of your coverage.

Essential health benefits apply for individuals buying coverage and for small companies buying coverage for their employees. Large companies often negotiate a custom package of benefits that may be somewhat different from the essential health benefits list.

Coverage for essential health benefits must be included in individual plans and in plans offered by small employers sold both within and outside of the Health Insurance Marketplace.

Grandfathered health plans do not have to offer all of the essential health benefits.*

**Grandfathered health plans are those that existed on or before March 23, 2010, and have met specific guidelines to remain exempt from certain aspects of the ACA.*

Most new individual and small employer health plans must provide essential health benefits. However, in March 2014, the U.S. Department of Health and Human Services announced that states may allow health insurers to renew existing health insurance plans that do not meet all of the requirements of the ACA (including the requirement for most plans to cover essential health benefits).

10 Qualified Health Plans

One of the most important aspects of the Affordable Care Act is the Health Insurance Marketplace. On October 1, 2013, people began to shop for, compare, and buy health coverage through the Marketplace.

The ACA's creators wanted the Marketplace to include clear, reliable information so that consumers like you can make good health coverage decisions.

To manage the Marketplace, the ACA requires that health insurers have their coverage plans certified as **qualified health plans**. Only qualified health plans can be sold through the Marketplace.

It is not easy for insurers to earn certification for their coverage plans. There are many requirements. Insurers have to agree that they will offer insurance to people regardless of any illness or health condition. They must also offer standard benefits and a sufficient network of health care providers. And they must provide standard coverage levels (60%, 70%, 80%, or 90% actuarial value) through plans that meet all other ACA guidelines.

In addition, qualified health plans can only be sold by an insurer that:

- Has a state license.
- Agrees to offer at least one Gold and one Silver Marketplace-coverage-level plan.
- Agrees to charge the same rate for the plan whether it is purchased through the Marketplace or directly from the insurer.

Certification Requirements

Here is a list of some of the things that insurers must do to gain certification.

To become a qualified health plan, a coverage plan must:

- Cover the essential health benefits package.
- Meet requirements that do not discourage individuals with significant health needs.
- Provide a sufficient network of health care providers.
- Include essential providers who will serve low-income and medically underserved individuals.
- Be accredited on clinical quality measures and consumer assessment surveys.
- Have a quality improvement strategy.
- Use a uniform enrollment form.
- Present benefits and plan options in a standard format.
- Meet other quality and reporting requirements.

Insurers will sell health coverage on the Health Insurance Marketplace. Those coverage plans must be certified as qualified health plans.

11 Individual Shared Responsibility

If you live in the United States, you will make one of these three health care decisions:

- You will obtain or maintain qualifying health coverage.
- You will pay a penalty to the Internal Revenue Service (IRS) for not having coverage.
- You will be one of the few who file for and receive an exemption.

The Affordable Care Act mandates that most people have health coverage or pay a penalty.

The ACA was largely based on the idea that everyone should be covered.

Often referred to as **individual shared responsibility**, this provision is important. It requires almost everyone to have health coverage, which helps ensure that people stay healthy and more evenly spreads out the costs of coverage. Everyone will share the responsibility of having coverage so that it's there when you – or your neighbor – need it most.

Some of the newly insured under this ACA provision will have low incomes. Financial assistance is available for low- to moderate-income individuals (see **Fast Fact #5** on page 15).

Seeking Balance

This is the balance created by the ACA:

- Everyone should have coverage (including the young and healthy).
- Nobody will be turned away or pay higher premiums because of their health condition (like people with diabetes or high blood pressure).

So, all of us – young, old, healthy, and not so healthy – are bound together in a way that aims to create balanced, stable premiums.

Paying the Penalty

Some people will no doubt decide to pay the IRS instead of buying health insurance. Here's what they will pay:

Penalty is either a flat amount or a percentage of income, whichever is greater.

	Flat Amount				Percentage of Income
	Adult	Child	Family Maximum		Percentage of Income
2014	\$95	\$47.50	\$285	or	1.0%
2015	\$325	\$162.50	\$975	or	2.0%
2016 and beyond	\$695	\$347.50	\$2,085	or	2.5%

1/12 of the total penalty is assessed for each month someone lacks insurance. However, there is no penalty for a single gap in coverage of less than three continuous months (see **Fast Fact #18** on page 29).

Individual Shared Responsibility, cont.

What About Exemptions?

Members of certain groups do not have to pay the penalty:

- Members of a religion opposed to health insurance
- Undocumented immigrants
- People who are in jail
- Members of an American Indian tribe
- Low-income people who do not have to file a tax return
- Anyone who must pay more than 8 percent of his or her income for health insurance.

What Is Qualifying Health Coverage?

Health coverage qualifies if it provides “minimum essential coverage.” Most people with coverage are already qualified. If you have standard health coverage through work, an individual policy, Medicare, Medicaid, or CHIP, you qualify!

Many individuals and families bought health insurance for the first time in 2014. Those who chose to remain uncovered will owe a penalty when they file their 2014 tax return. Financial assistance will be available for people with low to moderate incomes. When everyone has coverage, costs can be spread out to help keep premiums stable.

12 Employer Shared Responsibility

The legislators who crafted the Affordable Care Act needed a way to encourage employers to provide adequate coverage for their workers. There are fines for employers who don't offer coverage or whose coverage doesn't meet certain standards.

Starting in 2015, larger employers (100 or more full-time workers*) will have to pay fines if they do not offer adequate health coverage to 70 percent of full-time employees and their children.

Rules of the Game

Employers can avoid paying a fine if they:

- Provide minimum essential health coverage to 70 percent of full-time employees and their children.
- Make sure the coverage is affordable.
- Make sure the coverage offers minimum value.

Here are some important details on the above points.

Affordable. Coverage is affordable if an employee's share of the premium is no more than 9.5 percent of his or her yearly household income. So, if a single worker earns \$100,000 a year, health coverage is affordable if the employee premium is \$9,500 or less.

Minimum essential coverage. This is standard health care coverage, such as that supplied by government programs (Medicare, Medicaid, etc.) or typically sold to employers.

Minimum value. This is a plan that covers at least 60 percent of an employee's average costs for covered health services.

If a company does not offer minimum essential health coverage, the company may pay a fine. If the company offers coverage, but it is not affordable or does not provide minimum value, the company may also pay a fine.

Fines Are Not so Fine

There are a lot of aspects to employer fines. The simplest explanation is that employers who do not offer health coverage or who offer limited or unaffordable health coverage can pay fines.

Fines are triggered by at least one worker being approved for an Advance Premium Tax Credit or cost-share reduction. This can happen when an employee buys coverage from the Marketplace because his or her employer does not offer coverage, offers coverage that does not provide minimum value, or offers coverage that is not affordable for that employee.

Fine A: \$2,000

Employers (with at least 100 full-time workers) pay penalties of \$2,000 per worker if they do not offer a plan with minimum essential coverage and any of their employees claims an Advance Premium Tax Credit. The ACA offered one break: the first 30 employees will not be counted. So, a company with 50 workers would pay \$40,000 in fines (20 employees x \$2,000).

Fine B: \$2,000 to \$3,000

Employers who offer minimum essential coverage, but that coverage is not affordable or does not provide minimum value, may pay a fine for each employee that claim a tax credit. The fine is \$3,000 multiplied by the number of workers getting the tax credit, up to a maximum of \$2,000 multiplied by the number of full-time workers (minus the first 30 workers). The employer can choose the least-costly penalty.

** As defined by the ACA, a full-time employee is an employed individual who works least 30 hours of service per week. The law uses a "full-time equivalent" test, which means employers must also count the hours of their part-time employees. For example, two employees who work half-time each week would count as one full-time employee.*

13 IRS Reporting

The Affordable Care Act directed the Internal Revenue Service (IRS) to collect fines from people and businesses.

These fines occur when:

- People do not have health coverage.
- Businesses do not offer affordable coverage.

To do its job, the IRS will begin collecting new information on people and businesses.

Information About You (Provided by Health Insurers)

Health insurers will give the IRS information about their members in 2015.

The government is still working things out, but information reported to the IRS is expected to include basics like your name and address and information about your health coverage.

Information About Coverage (Provided by Employers)

Large employers will have to give the IRS details about their employees' health coverage.

The first reports containing this information will be required in 2016, although some employers may voluntarily choose to report this information to the IRS in 2015.

These large employers must also give employees a written statement to tell them about information provided to the federal government. This statement must be provided each year by January 31.

The Affordable Care Act has directed the IRS to get new information about you. The information will be used to determine who has health coverage and who does not.

14 Employer Cost Transparency

When you get your W-2 income tax statement next year, there is a good chance it will include a new piece of information.

The Affordable Care Act requires employers to put their cost of providing health coverage on the form.

Many employers will provide this information, but not all. These employers temporarily do not have to provide coverage cost information:

- Employers filing fewer than 250 W-2s
- Employers offering multi-employer plans
- Employers that provide coverage through health reimbursement arrangements
- Self-insured plans not subject to COBRA rules

The W-2 information will help the Internal Revenue Service enforce some of the ACA provisions.

Void ☐		Employee's social security number		OMB No. 1545-0048	
b Employer identification number (EIN)		1 Wages, tips, other compensation		2 Federal income tax withheld	
c Employer's name, address, and ZIP code		3 Social security wages		4 Social security tax withheld	
		5 Medicare wages and tips		6 Medicare tax withheld	
		7 Social security tips		8 Allocated tips	
		9		10 Dependent care benefits	
d Control number		11 Nonqualified plans		12a See instructions for box 12	
e Employee's first name and initial Last name		13 Retiary		12b	
		14 Other		12c	
				12d	
f Employee's address and ZIP code					
15 State Employer's state ID number		16 State wages, tips, etc.		17 State income tax	
				18 Local wages, tips, etc.	
				19 Local income tax	
				20 Locality name	

Form **W-2** Wage and Tax Statement
Copy D — For Employer

2013

Department of the Treasury—Internal Revenue Service
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Your employer's cost for providing your health coverage will appear here.

15 Marketplace Notices

Depending on where you work, you may get a notice from your employer about your health coverage options.

Employers have to provide the notice if they are subject to the Fair Labor Standards Act (note: this Act applies to most employers).

The notice will tell you about:

- The availability of the Health Insurance Marketplace.
- Eligibility for an Advance Premium Tax Credit through the Health Insurance Marketplace.
- Potential to lose employer health contributions if you buy health coverage through the Marketplace.

The notices are an important part of telling people that the Marketplace is available. In some cases, people may get the best coverage as well as subsidies through the Marketplace.

16 Automatic Enrollment

Few things in life are truly easy, but auto-enrollment is pretty simple.

To auto-enroll, you do nothing.

The federal government liked that idea so much it included it in the Affordable Care Act.

The ACA requires large employers to provide auto-enrollment. The provision affects employers that:

- Offer health coverage; and,
- Have more than 200 full-time employees.

Auto-enrollment means new, full-time employees will be automatically enrolled in health coverage offered by their employer. It also means existing employees will be auto-enrolled each year.

This process ensures that consumers will not unknowingly lose coverage because they forgot to enroll.

While auto-enrollment is easy for consumers, it actually provides some chores for employers. Employers must notify employees about their options. Those options include the chance to opt out of any coverage in which the employee would be automatically enrolled.

Mandated auto-enrollment has not started yet.

Currently, employers do not have to comply with this requirement. They won't have to do anything until the Department of Labor offers additional guidance. This should happen sometime in the near future.

17 Taxes and Fees for Health Insurers

The Affordable Care Act uses taxes and fees to support health care reform.

Research

The ACA placed a fee on health insurers and certain employers to support a research group created by the ACA. The group is called the Patient-Centered Outcomes Research Institute (PCORI). Insurers must pay an annual fee of about \$2 for each member enrolled in their plans, plus a percentage increase yearly.

The Institute will use money from the fee to support health care research. It will set a research agenda and support the agenda by providing grants to researchers.

Projects supported by the Institute are expected to provide new health information in these areas:

- Prevention
- Diagnosis
- Treatment

The **UPMC Center for High-Value Health Care** was one of the first groups to win a grant from the Institute. The grant focuses on helping adults with serious mental illness manage their condition better, by becoming more active in their health care. You can learn more about this grant at **www.upmchighvaluehealthcare.com**.

Funding for PCORI's research under the ACA ends in 2019. It is expected to provide a total of \$3.5 billion in funding for the Institute's projects.

The federal government places the fee on insurers and companies that self-fund their health coverage. Fees are not collected for Medicare, Medicaid, and CHIP beneficiaries.

Risk Fees for Insurers

The ACA uses a variety of risk management tools to help stabilize and spread risk among insurers. For example, if one insurer has members who, on average, need a lot more care than members of other insurers, that can make coverage much more costly for the insurer to maintain over time. The ACA collects fees from many insurers and places them in a pool that can be used to help offset the unexpected, higher-than-average costs of one or more insurers in the pool.

With risk management in place, insurers will set fair premiums knowing that the risk of unexpected costs is at least partly reduced.

The risk management programs include:

Risk adjustment. Health plans that cover a lot of healthy or low-risk people will pay a fee. Money will be distributed to plans that cover a high number of people with complex illnesses or serious chronic health conditions. This program makes it easier for the government to require that health plans offer coverage for people with existing medical problems.

Reinsurance. Reinsurance is a standard concept used in all kinds of insurance. In addition to selling insurance, many insurers buy reinsurance to protect the financial stability of their business – this helps ensure that they can cover the claims of all their members over time. Reinsurance pays insurers when they have unexpected high costs. Under the ACA, a universal reinsurance program for individual coverage will be supported by fees on health insurers and on self-insured plans. The fees were collected in 2014, and will also be collected in 2015 and 2016.

Risk corridors. In 2015 and 2016, Marketplace insurers that have low medical costs will pay a certain amount to the federal government. Those funds will be used to pay other Marketplace insurers that have higher-than-expected medical costs.

Taxes and Fees for Health Insurers, *cont.*

Premium Tax

Fully insured plans must pay a premium tax. Here are a few details:

- In calendar year 2014, the total burden of the tax is \$8 billion.
- The tax will be placed on each health insurer based on market share.
- It may add 2 to 3 percent to premiums.

This permanent tax increases in total cost every year. The effect on premiums is likely to grow.

Excise Tax on High-Cost Employer-Sponsored Health Coverage (“Cadillac” Tax)

Starting January 1, 2018, plan administrators (for self-funded plans) or insurers must pay an excise tax. The 40 percent tax is for employer-sponsored coverage valued above \$10,200 for individuals and \$27,500 for family coverage.

The tax is commonly called the **Cadillac Tax**.

Details of this tax are still being worked out. The value thresholds may be adjusted to reflect:

- Age and gender
- Employees engaged in high-risk professions
- Retirees aged 55 and older who are ineligible for Medicare
- Cost of living

The federal government will be collecting taxes and fees to support ACA initiatives.

The dollar values are subject to adjustment based on a specific inflation factor measured between 2010 and 2018.

18 Coverage Waiting Period

Sometimes a person accepts a job and then quits within a month. Because of that possibility, employers and insurers often have health coverage waiting periods.

Waiting periods are times in which a new worker is not yet eligible to enroll in health coverage from their employer.

The Affordable Care Act does not allow employers to use waiting periods of more than 90 days.

It is not an employer’s fault if a new worker does not sign up for health coverage when the 90-day waiting period ends. Also, employers are allowed to have other restrictions on who can have health coverage. For example, a professional certificate may be required. Employers can deny health coverage until the certificate is earned. However, employers cannot use restrictions to purposely lengthen the waiting period beyond 90 days. One exception includes the employer’s ability to offer a one-month orientation period before the 90-day waiting period begins.

Some employers only offer coverage to full-time employees, or require an employee to work a certain number of hours over a period, say 800 hours over six months, before being eligible for coverage. But many workers have flexible hours. In that case, it may take time to see whether a new worker will work enough hours to be eligible for health coverage. The ACA allows for a reasonable period in which employers can decide whether a new flexible-hour worker will satisfy all requirements to be eligible for the employer’s health coverage.

Waiting periods are defined as “the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective.”

Companies and insurers cannot have waiting periods of more than 90 days for new-employee health coverage to begin.

19 Insurer Efficiency

The ACA encourages health insurers to efficiently use premiums to pay for members' health care costs.

This involves something called a **medical loss ratio**. This is a ratio that shows how much of each premium dollar an insurer collects is spent on clinical health care, and how much is spent on running the insurance company.

Efficient health insurers spend most of their premiums on quality improvement and health care for their members, and only use a little to cover operating costs.

The Affordable Care Act requires insurers to spend at least:

- 80 percent of premiums on clinical care and quality improvement for all their plans in the small group and individual market
- 85 percent of premiums on clinical care and quality improvement for all their plans in the large group market

What happens if an insurer doesn't spend enough on clinical care and their medical loss ratio is below the required percentage? They must pay a rebate. The rebate, in most cases, goes back to employers (who can then distribute the employee share of premiums back to workers). But the rebate will go directly to individuals if they bought their own health coverage. If your insurer owes you a rebate, you will receive a notice that explains why.

Rebates must be issued by August 1 of each year.

Medical Loss Ratio Examples:

80 percent spent on health care

+

20 percent spent on administrative

=

Great news!
Your insurer is using your premiums efficiently.

75 percent spent on health care

+

25 percent spent on administrative

=

Your insurer is less efficient and must pay rebates.

30

Insurer Efficiency, cont.

Rate Review

In addition to the medical loss ratio, the ACA also requires state and federal governments to review significant health coverage rate increases.

The reviews began in 2011.

When insurers propose annual rate increases of more than 10 percent, they are reviewed to determine whether they are reasonable. In addition, the reviews make information available to consumers.

Easy-to-read reviews for Pennsylvania (visit www.pahealthoptions.com) and other states are now available.

The Pennsylvania Insurance Department reviews insurance rates in the individual and small group markets.

If an insurer's rates are determined to be unreasonable, the insurer must provide more information.

A state can ban insurers from the Health Insurance Marketplace if they have a record of unreasonable rate proposals.

20 Summary of Benefits and Coverage

Insurance company information is sometimes complicated.

To help simplify things, the Affordable Care Act mandated the use of a clear document built on one, standard template.

This document is called a uniform **Summary of Benefits and Coverage (SBC)**. This is what it looks like:

Summary of Benefits and Coverage: What This Plan Covers & What It Costs

Coverage Period: [See Instructions]
Coverage for: [Plan Type]

A **Coverages** = fixed dollar amounts (for example, \$15) you pay for covered but don't owe, usually when you receive the service.

- Coinurance** = your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 25% would be \$250. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ providers by changing you have **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness			
If you have a test	Specialist visit Other practice office visit Preventive care (screening/prevention)			
If you need drugs to treat your illness or condition	Diagnostic test (e.g., blood work) Imaging (CT/MRI scans, X-rays) General drugs Preferred brand drugs Not preferred brand drugs			
More information about prescription drug coverage is available at www.[plan]	Specialty drugs			
If you have major surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees			

Questions: Call 1-800-[number] or visit us at [www.\[plan\]](#).
 If you aren't clear about any of the information found in this form, see the Glossary. You can view the Glossary at [www.\[plan\]](#) or call 1-800-[number] to request a copy.

2 of 6

SBCs are available now. You can probably find your SBC on your insurer's website. For UPMC Health Plan members, they are available through MyHealth OnLine, or you can call and request one using the Member Services phone number on the back of your member ID card.

SBC information includes:

- Summaries of the key features of the plan or coverage
- Covered benefits
- Cost-sharing
- Coverage limitations and exceptions

All of that information is written so that you can easily understand the basic terms of your coverage.

The documents also include examples of how your health plan would cover costs in two health care scenarios, including having a baby and managing diabetes.

Remember: The SBC is a great tool for understanding the basics of your plan, but it is only a Summary. It is not a replacement for a coverage certificate, policy, or contract.

RESOURCES

Health Insurance Marketplace: www.healthcare.gov
Internal Revenue Service: www.irs.gov
PA Insurance Department: www.pahealthoptions.com
Department of Health and Human Services: www.hhs.gov
UPMC Center for High-Value Health Care: www.upmchighvaluehealthcare.com
UPMC Health Plan: www.upmchealthplan.com

Visit **www.upmchealthplan.com/reform** for more information about health care reform and to learn about UPMC *Advantage* health insurance plans for individuals and families.

CONTACT US

If you have questions about health care reform or UPMC *Advantage* health insurance plans for individuals and families, contact us Monday through Friday from 8 a.m. to 5 p.m.

General Information about Health Care Reform: 1-855-230-8762
Individuals and Families: 1-855-489-3494 | Email: marketplaceinfo@upmc.edu*
Employers: 1-855-489-3495
Producers: 1-855-514-3670
Providers: 1-866-918-1595
Navigators/Certified Application Counselors: 1-855-498-8762

Visit us at one of these convenient UPMC Health Plan Connect Service and Sales Center locations:

- Century III Mall
- The Mall at Robinson
- Monroeville Mall
- Ross Park Mall
- South Hills Village
- Millcreek Mall (Erie)

**Please do not send us any personal health information such as health status, prescription use, illness, or injury. Email is typically not encrypted and your information may not be protected. We will not answer any personal health information questions through email. We encourage you to call us with specific questions.*

ABOUT UPMC HEALTH PLAN

UPMC Health Plan, the second-largest health insurer in western Pennsylvania, is owned by UPMC, an integrated global health enterprise. The integrated partner companies of the UPMC Insurance Services Division – which includes UPMC Health Plan, UPMC WorkPartners, *LifeSolutions* (EAP), UPMC *for You* (Medical Assistance), and Community Care Behavioral Health – offer a full range of group health insurance, Medicare, Special Needs, CHIP, Medical Assistance, behavioral health, employee assistance, and workers' compensation products and services to nearly 2.3 million members. Our local provider network includes UPMC as well as community providers, totaling more than 135 hospitals and more than 11,500 physicians throughout Pennsylvania and parts of Ohio, West Virginia, and Maryland. For more information, visit **www.upmchealthplan.com**.

DISCLAIMER

This booklet is provided for informational purposes only. Information provided is based on available guidance at the time of preparation and may be subject to change. These materials do not constitute legal or other professional advice. You should not act, or refrain from acting, solely on the basis of information included herein without first seeking appropriate legal counsel or other professional advice.

the 1990s, the number of people in the UK who are employed in the public sector has increased by 1.5 million (1990–1999), and the number of people in the public sector who are employed in health care has increased by 1.1 million (1990–1999) (Department of Health, 2000).

There is a growing emphasis on the importance of the public sector in the provision of health care services, and the need to ensure that the public sector is able to meet the needs of the population. This has led to a number of initiatives to improve the performance of the public sector, including the introduction of the Health Service Act 1999, the Health Service Act 2001, and the Health Service Act 2004. These initiatives have led to a number of changes in the way that the public sector is organized and managed, and to a number of improvements in the way that health care services are provided.

One of the key areas of focus for these initiatives has been the need to improve the efficiency of the public sector. This has led to a number of initiatives to improve the efficiency of the public sector, including the introduction of the Health Service Act 1999, the Health Service Act 2001, and the Health Service Act 2004. These initiatives have led to a number of changes in the way that the public sector is organized and managed, and to a number of improvements in the way that health care services are provided.

Another key area of focus for these initiatives has been the need to improve the quality of health care services. This has led to a number of initiatives to improve the quality of health care services, including the introduction of the Health Service Act 1999, the Health Service Act 2001, and the Health Service Act 2004. These initiatives have led to a number of changes in the way that the public sector is organized and managed, and to a number of improvements in the way that health care services are provided.

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