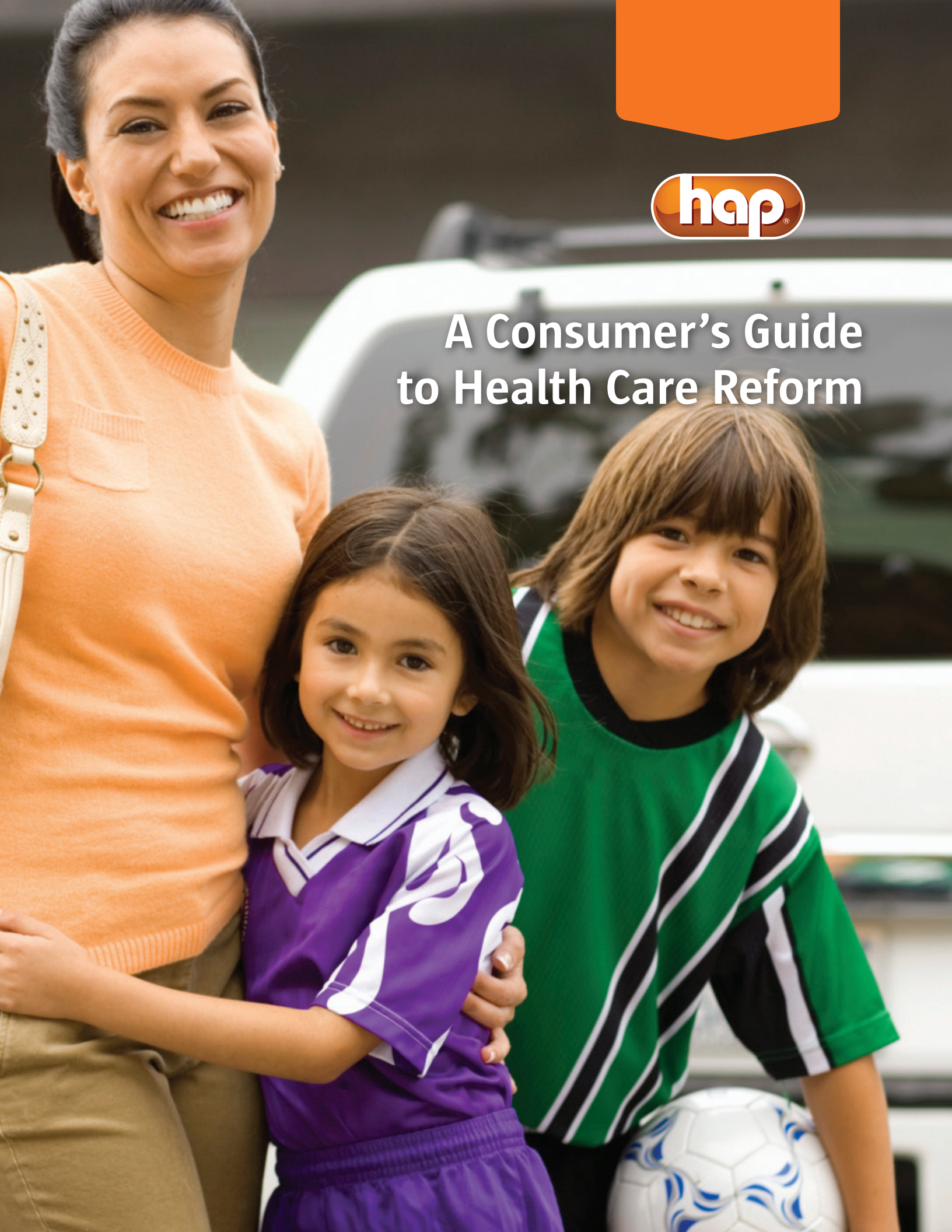

A Consumer's Guide to Health Care Reform

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Health Care Reform

Health care is in for big changes.

It's called many names, but the official health care reform law, signed in 2010, is called the Patient Protection and Affordable Care Act (PPACA or just ACA). It was designed to improve access to health care for everyone. While some parts of the law are already in place, most of the major provisions of ACA become effective in 2014. These changes are aimed at making health coverage more accessible and affordable for many more people. They include the creation of Health Insurance Marketplaces (also called Exchanges), coverage of Essential Health Benefits (EHBs) and individual tax credits. There will be even more changes coming over the next several years.

With the ACA, you cannot be denied coverage, or pay a higher rate, based on a pre-existing condition. Most people will be required to have health insurance coverage starting in 2014 or pay a fine. Many kinds of coverage will satisfy this requirement, including private insurance obtained on your own or through a job, Medicare, Medicaid, Children's Health Insurance Program (CHIP), Veterans Affairs, the Indian Health Service and Tricare.

Some ACA benefits are already available.

Health plans already have broader coverage because of the ACA. Here are some of the new benefits available now:

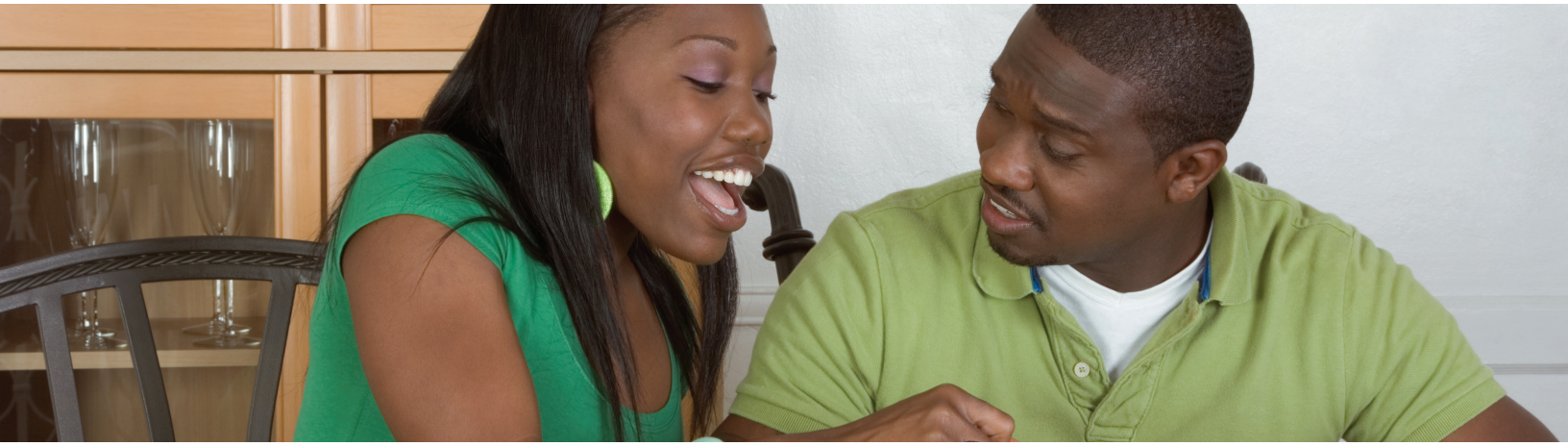
- Young adults can remain on a parent's health plan until the age of 26, even if they live away from home, attend school, or are married
- Preventive care and women's preventive services with no copays, coinsurance or deductibles
- Children with pre-existing conditions can't be denied coverage
- No lifetime dollar limits on coverage

Plus, health plans can't cancel coverage if you get sick. They can only cancel coverage for nonpayment of premiums or if someone committed fraud when they applied for health insurance.

All health plans must also use the same standard form to help you compare plans. The Summary of Benefits and Coverage (SBC) is a short, plain-language overview of what is covered, along with copays, coinsurance and deductibles. The SBC also includes coverage examples that allow you to see how much a member would typically pay in two common medical situations: Type 2 diabetes care and childbirth.

In addition, health insurance companies are now expected to spend at least 80 percent of premiums on medical claims and activities that improve the quality of care for members in individual and small group plans (85 percent for large group plans). If an insurance company does not meet these targets, members or employer groups will receive the difference in the form of rebates or reduced premiums.

Coverage for Everyone



It's time to get health insurance.

There are many new options for adults under the age of 65 who are uninsured, underinsured or who have individual coverage that is not through an employer. The Health Insurance Marketplace allows you to compare health plans based on price, benefits, quality and other important features.

Individual Mandate

People who do not have qualified coverage may face tax penalties. The level of these penalties is set to increase over the next several years. For the 2014 tax year it will be $95 per person or one percent of a household's taxable income, whichever is greater. The penalty amount decreases by one-half for dependents under the age of 18.

You will not pay a penalty if any of the following apply:

- You do not make enough money to file a federal tax return
- You have to spend more than eight percent of your household income on the least expensive plan available
- You have a hardship that prevents you from becoming insured (known as the "hardship exemption")

Other groups exempt from the mandate include:

- Americans living abroad
- People who go without insurance for less than three months in a row per year
- Certain religious affiliations
- Members of a federally recognized Indian tribe

If you believe you are exempt, you can apply for an exemption through the Federal Government. You would make this request through the Health Insurance Marketplace.

Open Enrollment

Whether buying a health plan directly from HAP or through the Health Insurance Marketplace, you will only be able to apply or make changes during open enrollment.

If you enroll between December 24, 2013 and January 15, 2014 you will have an effective date of February 1, 2014. Effective dates are always the first of the month.

There are exceptions that allow you to enroll in a health plan outside the open enrollment period. In each case, you must enroll within 60 days of a life-changing event. These include, but are not limited to:

- The loss of a job
- You become eligible/ineligible for lower costs due to a salary change
- Marriage
- The birth of a child

Buying Coverage

Where to buy health insurance

There are three ways to buy a health care plan – through insurance companies like HAP, through the Health Insurance Marketplace, or through an agent (also known as a broker). There are also Navigators available to help guide you through the Health Insurance Marketplace.

Through HAP

You can purchase a HAP health plan for individuals and families through HAP or through the Health Insurance Marketplace. You can rest assured that all HAP health plans, whether you join through HAP or through the Health Insurance Marketplace, will have the same high standards for coverage, quality and customer service. For more information please visit **chooseHAP.org**, or call us at toll-free at **(855) WITH-HAP**.

Through the Health Insurance Marketplace

The Health Insurance Marketplace – sometimes called the Exchange – is where you can compare and select qualified health plans. You will be able to shop online, by phone, or with the personal assistance of specially trained helpers called Navigators.

In Michigan, the Health Insurance Marketplace will be operated by the federal government and not by the state. To compare and shop for health plans, you would go to **www.healthcare.gov**. There you'll also find answers to many of the most common questions about the Health Insurance Marketplace.

Through an Agent (Broker)

Licensed, specially trained health insurance agents/brokers can also guide you through the task of choosing coverage that meets your unique needs. You can find agents online or in the phone book.

Navigators

Specially trained individuals and groups called Navigators will be available, in-person or by phone, to help you with the Health Insurance Marketplace application process and answer questions. They will be paid by the government and will not be allowed to favor one health plan over another. Navigators will also help you understand your coverage options, which may include Medicaid or lower cost options through the Health Insurance Marketplace. Groups eligible to act as Navigators include: unions, tribal organizations, church groups and chambers of commerce. At least one group in every state must be a consumer-oriented nonprofit. Another category of helpers, called “Certified Application Counselors,” will help consumers with the application process at community health centers, hospitals, social service agencies and similar institutions.

Checklist for Open Enrollment

Make sure you're ready.

Here are some things you can do now to get ready for open enrollment.

1. Have an idea of what you want out of a health care plan.
2. Make sure you understand how coverage works (insurance premiums, deductibles, copays, coinsurance, etc.).
3. Write down a list of questions.
4. Gather basic information about your household, such as:
    - Number of people in your family who need insurance
    - Monthly household income and expenses
    - Personal information on each person to be covered (date of birth, Social Security number, etc.)
5. Set a budget – how much you can afford to spend every month on health insurance?
6. Have a go-to doctor in mind for you and members of your family that will be covered under the plan.
7. Make a list of any medications you or your family member takes so you can check if those medications are included in the health plan's drug formulary. To view HAP's drug Formulary visit us at **hap.org** under the Prescriptions tab.

Lower Cost Eligibility

There may be help available.

Lower cost eligibility through the Health Insurance Marketplace

If you buy coverage through the Health Insurance Marketplace, you may be eligible for cost savings based on your family size and how much your family earns. The lower your income, the higher your savings may be. If you are eligible, you will receive a cost savings that can be applied directly to your monthly premiums. You may also be eligible for lower copays, coinsurance and deductibles. To learn if you are eligible for these savings, visit **www.healthcare.gov** or **www.kff.org/interactive/subsidy-calculator**.

Federal Poverty Level guidelines

Each year, the U.S. Department of Health and Human Services issues Federal Poverty Level (FPL) guidelines to determine financial eligibility for certain federal programs and benefits. In health care reform, for example, some level of help is available for qualifying individuals and families making 400 percent or less of the FPL. Cost-sharing opportunities (reduced copays, coinsurance and deductibles) are also available for those with income between 100-250 percent of the FPL.

2013 levels, by family size:

Number of family members	100% FPL	250% FPL	400% FPL
1	$11,490	$28,725	$45,960
2	$15,510	$38,775	$62,040
3	$19,530	$48,825	$78,120
4	$27,570	$58,875	$94,200

(The FPL numbers are likely to be somewhat higher in 2014.)

Some parts of health care reform will likely increase consumer costs while other parts will likely help lower costs.

How health care reform may increase costs for some consumers:

- **Rating regulations** – Starting in 2014, the law limits how much premiums can vary based on age. Some younger people will get less of a break on premiums than they did in the past.
- **Benefit regulations** – Since health plans will be required to cover some health care services they may not have covered before (10 categories of Essential Health Benefits), premiums could increase for individuals whose plans had leaner coverage prior to health care reform.
- **Taxes and fees** – Health care reform includes taxes and fees that health plans have to pay to support parts of the law, such as lower costs for low- and middle-income individuals and families.

How health care reform may lower costs for some consumers:

- **Rating regulations** – Starting in 2014, the law limits how much premiums can vary based on age. Some older people will get a better break on premiums than they did in the past, and someone who has a pre-existing medical condition will no longer have to pay more than someone who doesn't.
- **Lower costs based on income** – Low- and middle-income individuals and families using the Health Insurance Marketplace may be eligible for lower premiums and out-of-pocket costs.

Guaranteed Coverage

You are covered. Guaranteed!

In 2014, health plans cannot deny coverage or charge a higher premium to someone with a pre-existing medical condition. These protections are commonly referred to as *guaranteed issue*.

Health plans will also be required to cover Essential Health Benefits (EHBs), which include at least the following 10 categories of health care services:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization
- Maternity and newborn care (care before and after your baby is born)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric vision and dental services

Metal Tier Plan Levels

The Metal Tiers: Bronze, Silver, Gold and Platinum

Starting in 2014, health plans will be ranked using metal tiers: Bronze, Silver, Gold and Platinum. The idea behind "metal level plans," or metal tiers, is to allow consumers to compare health plans with similar coverage value (the technical term is actuarial value).

What this means is that health plans offered to individuals and families through HAP or the Health Insurance Marketplace will be grouped in different metal tiers based on the percentage of health care costs the health plan covers. A catastrophic health plan is available through HAP or the Health Insurance Marketplace for individuals and families who are under 30 or who are exempt by the government from the coverage mandate.

A health insurer's Bronze health plans usually will have the lowest premiums and highest out-of-pocket costs – copays, deductibles and coinsurance – while Platinum health plans usually have the highest premiums and the lowest member cost sharing. However, it is also possible that lower tier health plans offered by one insurer may be less expensive than another insurer's higher tier health plans. Insurers selling coverage to individuals and families may offer several different options within a given metal tier, but they are not required to offer health plans in all four tiers.

		Percent of Actuarial Value*	Monthly Premium	Cost when you get care
Platinum		90%	$$$$	$
Gold		80%	$$$	$$
Silver		70%	$$	$$$
Bronze		60%	$	$$$$

* A health insurance plan's actuarial value is the average share of medical spending that is paid by the plan and not by the member. As a general rule: the higher the actuarial value, the less cost-sharing responsibilities (deductibles, copays and coinsurance) for the member, but the higher the premium.

Summary of Benefits and Coverage

Understanding and Comparing Health Coverage

Whether you're choosing or using a health plan, it's important to understand what benefits are covered and what you may have to pay when you need care. But let's face it, the coverage rules and terms used in health insurance can be complicated and unfamiliar.

The federal health care reform law (also known as the Affordable Care Act) has introduced two new tools to make it easier to understand and compare what different health plans offer. They are:

- A simplified Summary of Benefits and Coverage (SBC)
- A uniform Glossary of Health Coverage and Medical Terms

The SBC is a simple, high-level overview of what a health plan covers and what you'll need to pay when you get covered services. As you'll see on any SBC, some key words are underlined. If you are unsure what they mean, you can look them up in the Glossary.

What's in a Summary of Benefits and Coverage?

At the top of the first page (see sample included), you'll find the name of the insurance company, the dates the coverage begins and ends (the Coverage Period), the type of coverage (Individual, Individual & Spouse, or Family), and the Plan Type.

Some details to look out for:

- The SBC doesn't include information on the plan's monthly premium, but plans with higher deductibles often have lower monthly premiums than plans with lower deductibles.
- Your out-of-pocket costs will be lower if you use the plan's network of health care providers for covered services. (Some plans will have in-network benefits only.)

Here are some questions people ask when choosing or using a health plan:

- How much will I have to pay when I use services this plan covers? In other words, what, if any, deductible will I have to pay before the plan pays for covered services.
- Is there a limit on how much I will have to pay out-of-pocket during the coverage period?
- Are there rules or limits concerning which doctors I can use if I need covered services?

Copays and Coinsurance

This section includes important information about copays and coinsurance that you may be required to pay: for certain medical office visits, tests, prescription drugs, outpatient surgery (surgery that doesn't require hospitalization), emergency care, hospitalization, mental health, behavioral health and substance abuse care; or if you are pregnant or have certain other health needs.

Some details to look out for:

- There are likely to be different rules or payments depending on whether or not you use the plan's network of providers (get your care from an in-network provider versus an out-of-network provider).
- There are likely to be different rules or payments for different kinds of office visits, tests, and procedures (i.e., preventive visit, sick visit, visit with specialist).
- There may be limits on the number of visits the plan will cover.
- You may be required to pay more for certain tests or procedures if you don't receive preauthorization from the health plan.
- There are likely to be different rules or payments depending on whether your prescriptions are for generic drugs, brand-name drugs, or specialty drugs.
- There may be different rules or payments depending on the pharmacy you use.
- If you have surgery or require hospital care, the doctor and the facility (surgical center or hospital) may charge separate fees.

Excluded Services and Other Covered Services

Here you'll find:

- A list of some of the services your plan doesn't cover.
- A list of additional services that are covered but not explained in the SBC. You should check your more detailed plan documents for more information on what is covered and what isn't.

Other information you'll find in the SBC:

- Details of the special rights you have as a member of the health plan and how to use them.
- As of January 1, 2014, a statement will affirm whether or not the plan provides "Minimum Essential Coverage," which is the level of coverage the ACA's "individual mandate" requires most people to have in order to avoid paying a penalty.
- A statement affirming whether or not the plan will cover at least 60 percent of your anticipated medical expenses. This represents the minimum value a health plan's benefits must have under the ACA, based on the "metal plan" selected.
- Information on how to learn more and get help in languages other than English.

Coverage Examples

The SBC Coverage Examples show how the health plan might cover the costs of two fairly common medical situations – treating Type 2 Diabetes and childbirth.

Each example includes a list of possible medical costs based on national averages, the total cost of care, and a breakdown of how much of the bill the health plan would pay, and how much a patient with this coverage option would pay in deductibles, copayments, and coinsurance. (The example assumes the coverage deductible hasn't been reached, so the member is still responsible for the deductible.)

Since no two situations are alike, these examples are presented only to give you a general idea of how costs are shared between the health plan and the patient for this particular coverage option.

Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2014 – 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family For non-participating providers **$4,000** person / **$8,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.[insert].com or call 1-800-[insert]** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to	No. You don't need a referral	You can see the **specialist** you choose without permission from this plan.

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[**insert**] to request a copy.

Glossary of Health Coverage and Medical Terms

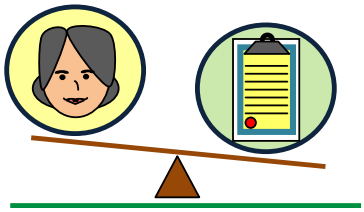
- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you 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 you for the remaining $30. A preferred provider may ***not*** balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance ***plus*** any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

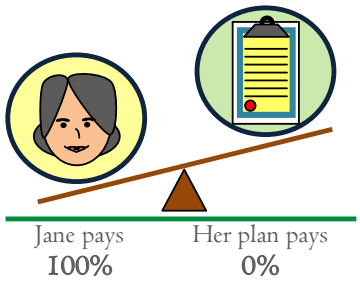


(See page 4 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

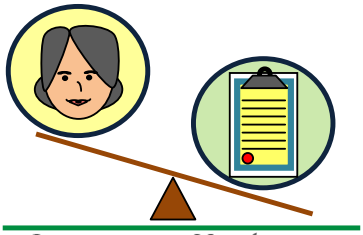
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

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

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do ***not*** contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit


The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

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.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
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.

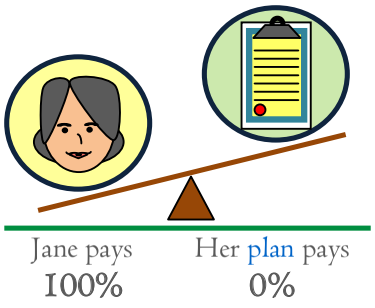
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

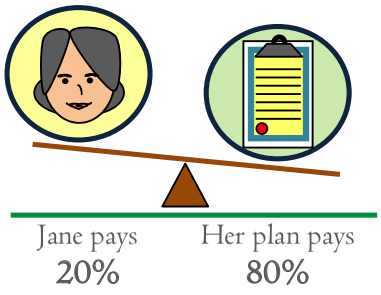


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

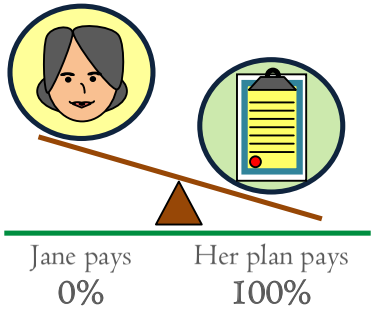


Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

Health Care Reform Terms to Know

Actuarial Value: The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70 percent, on average, you would be responsible for 30 percent of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

Affordable Care Act (ACA) (See also: Patient Protection and Affordable Care Act): The federal health care reform law enacted in March 2010.

Affordable Coverage: As it relates to the health care reform law, employer coverage is considered affordable if the employee's share of the annual premium for individual coverage is no greater than 9.5 percent of annual household income. Starting in 2014, individuals offered employer-sponsored coverage that's affordable and provides minimum value won't be eligible for a premium tax credit.

Catastrophic Health Plan: Some insurers describe this as a plan that only covers certain types of expensive care like hospitalization. Other insurers describe it as a plan that has a high deductible and begins to pay only after you've first paid up to a certain amount for covered services. On the Health Insurance Marketplace, to qualify for a catastrophic plan, you must be under 30 years old or get a "hardship exemption" because the Marketplace determined that you're unable to afford health coverage.

Cost Sharing: The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copays, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

Cost Sharing Reduction: A discount that lowers the amount you have to pay out-of-pocket for deductibles, coinsurance, and copays. You can get this reduction if you get health insurance through the Marketplace, your income is below a certain level, and you choose a health plan from the Silver plan category. If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.

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

Exchange (see also: Health Insurance Marketplace): A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. In some states, the Marketplace is run by the state. In others it is run by the federal government.

Federal Poverty Level (FPL): A measure of income level issued annually by HHS. Federal poverty levels are used to determine your eligibility for certain programs and benefits.

Grandfathered Health Plan: As used with the ACA: A group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Grandfathered 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 consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan.

HHS: The Department of Health and Human Services – the United States government's lead agency for protecting the health of all Americans. HHS is responsible for implementing the parts of the ACA that deal with private and public health insurance.

Health Insurance Claims Assessment Act (HICAA) Tax: A state tax applied to certain health insurance claims paid for services provided on or after January 1, 2012. Funds generated by the tax will support Michigan's Medicaid program.

Health Insurance Marketplace (see also: Exchange): A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. In some states, the Marketplace is run by the state. In others it is run by the federal government.

Health Insurance Premiums: The monthly fee paid for health insurance coverage for the duration of a defined benefit period.

Health Insurance Premium Tax: An excise tax assessed on all fully insured health plans, effective January 1, 2014, to help fund the ACA.

Health Savings Account (HSA): A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. If you don't spend them, funds roll over year to year.

Household Income: The sum of the modified adjusted gross income (MAGI) of the taxpayer and each member of the taxpayer's family who is a dependent and is required to file a return.

Individual Mandate (or Responsibility): Under the ACA, starting in 2014, you must be enrolled in a health insurance plan that meets minimum essential coverage. If you aren't you may have to pay a penalty. You won't have to pay a penalty if you have very low income and coverage is unaffordable to you, or for other reasons including your religious beliefs. You can also apply for a waiver asking not to pay a penalty if you don't automatically qualify.

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 will vary from state to state.

Medical Loss Ratio Requirements: Health plans must spend a minimum amount of premium revenue on medical claims and activities to improve health care quality.

Minimum Essential Coverage: The type of coverage an individual must have to meet the individual responsibility requirement under the ACA. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. The penalty for not having minimum essential coverage will be phased-in according to the following schedule: $95 per person in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1 percent of taxable income in 2014, 2 percent of taxable income in 2015, and 2.5 percent of taxable income in 2016.

Minimum Value: For an employer-sponsored plan to qualify as minimum essential coverage it must provide minimum value. Generally, a plan provides minimum value if the plan covers at least 60 percent of the total cost of benefits covered under the plan.

Navigator: An individual or organization that is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to not favor one insurer over another. Their services are free to consumers.

Out-of-Pocket Costs: Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include copays, coinsurance and deductibles for covered services plus all costs for services that aren't covered.

Patient Centered Outcomes Research Institute (PCORI) Fee: Funds the Patient-Centered Outcomes Research Institute (PCORI), which will produce and promote research on clinical effectiveness to help patients and their health care providers, make more informed health care decisions.

Patient Protection and Affordable Care Act (PPACA) (see also: Affordable Care Act): The federal health care reform law enacted in March 2010.

Premium/Financial Assistance/Subsidiary: Lower costs available to eligible individuals and families who purchase coverage on the Health Insurance Marketplace. The lower cost will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels:

- Up to 133% FPL: 2% of income
- 133%-150% FPL: 3%-4% of income
- 150%-200% FPL: 4%-6.3% of income
- 200%-250% FPL: 6.3%-8.05% of income
- 250%-300% FPL: 8.05%-9.5% of income
- 300%-400% FPL: 9.5% of income

Qualified Health Plan (QHP): An insurance plan that is certified for the Health Insurance Marketplace, provides Essential Health Benefits, follows established limits on cost sharing and meets other requirements established by the Marketplace in which it is offered.

Risk Adjustment Fee: An annual assessment for the administration of a risk adjustment program that will transfer funds from plans with membership that is healthier than average to those with membership that is less healthy than average, in order to reduce the impact of adverse selection. It will be applied to non-grandfathered small groups.

SHOP Exchange: Small Business Health Option Program or SHOP – the state-based insurance exchanges created by the health care reform law through which small employers will be able to purchase health insurance for their employees starting in 2014.

Subsidy/Advanced Premium Tax Credit: The amount of the monthly premium the government pays to help the taxpayer purchase health insurance. The subsidy is sometimes referred to as the advanced premium tax credit (APTC) or premium assistance and the amount is determined on a sliding scale based on income.

Tax Penalty: An additional tax assessed on individuals who fail to maintain minimum essential coverage and are not eligible for an exemption to the requirement. The penalty will be determined monthly, but generally will not apply if the individual was without health care for less than 90 days. The penalty is paid on the individual's tax return. The penalty is also sometimes referred to as a shared responsibility penalty.

Transitional Reinsurance Program: Funds a temporary program (2014-2016) intended to stabilize premiums for coverage in the individual market as high-risk individuals become newly insured. The program fee applies to fully insured and self-funded plans.

* Definitions compiled from hap.org, healthcare.gov, healthreformgps.org and the Journal of Recreational Accounting.

Frequently Asked Questions

These are some of the more popular health care reform questions. If you don't see your question here, give us a call toll-free at **(855) WITH-HAP**.

Q. I've heard that the government has delayed parts of health care reform. How will that affect me?
No parts of the law affecting individual consumers under 65 who do not have access to health insurance through an employer have been delayed.

Q. I want to keep my HAP health insurance, but my employer is switching to another health plan. Can I stick with HAP by getting my coverage through the Health Insurance Marketplace instead?
You can purchase HAP coverage from the Health Insurance Marketplace, but because you have access to coverage through your employer, you will not be eligible for a lower cost. With most job-based health insurance plans, your employer pays a portion of your premiums. If you choose a Health Insurance Marketplace plan instead, your employer does not need to make a contribution to your premiums. You should consider this carefully before choosing a Health Insurance Marketplace plan.

Q. My company offers health insurance to its employees, but I've chosen to be uninsured because it's too expensive. Can I get more affordable coverage from the Health Insurance Marketplace instead?
If you have access to health insurance through your employer, you can shop for coverage through the Health Insurance Marketplace, but you will not be eligible for a lower cost. With most job-based health insurance plans, your employer pays a portion of your premiums. If you choose a Health Insurance Marketplace plan instead, your employer does not need to make a contribution to your premiums. You should consider this carefully before choosing a Health Insurance Marketplace plan. You can also buy coverage from a health plan like HAP through **chooseHAP.org**.

Q. I'm getting health insurance through my company, but there are rumors they might drop it because of health care reform. What will happen to me if my company drops health coverage?
If your company drops health insurance for employees, you will be able to buy individual or family coverage, either directly from a health plan like HAP, or through the Health Insurance Marketplace. And, low- and middle-income individuals and families may be eligible to receive lower cost coverage through the Health Insurance Marketplace.

Q. I'm young and healthy and don't need a lot of health insurance. Can I buy limited coverage to save money?
HAP and the Health Insurance Marketplace will offer a catastrophic health plan that will cover the Essential Health Benefits, but only after a high deductible is met. Members won't have to pay the deductible for preventive care or for up to three primary care visits per year. Eligibility for the catastrophic health plan is restricted to either (1) young adults under age 30 prior to the start of the plan year or (2) individuals who get a "hardship exemption" from the Health Insurance Marketplace because they're unable to afford any other available health coverage.

The monthly premium should be lower than for other health plans offered in the Health Insurance Marketplace, but the out-of-pocket costs for copays, deductibles, and coinsurance are higher. In addition, catastrophic plans don't qualify for the premium savings and lower out-of-pocket costs that are available to low- and middle-income individuals through the Health Insurance Marketplace, so it's important to carefully compare all options.

Q. What is a "grandfathered plan" and how do I know if I have one?
Grandfathered plans are those that were already in place on March 23, 2010, when the health care reform law was enacted, and that have stayed largely the same since that time. Grandfathered plans are exempt from some health care reform provisions. For example, a grandfathered individual plan does not have to guarantee coverage for people with pre-existing medical conditions or year end dollar limits on coverage.

Even if you joined a plan after March 23, 2010, the plan may still be grandfathered. The status depends on when the plan was created, not when you joined it. You can find out if your plan is grandfathered by checking your plan's materials. Health plans must disclose if they are grandfathered in materials describing plan benefits. You can also check with your employer or your health plan's benefits administrator.

HAP Personal Alliance health plans do not have grandfathered plans.

Q. Can I get financial help paying for my Medicare coverage?
Although the premium savings in the health care reform law don't apply to Medicare, there are a number of lower cost programs available to help you pay your Medicare expenses if you are elderly or disabled with low income and limited assets. To find out if you might qualify, you should call your local Department of Human Services (DHS) office (in the telephone book under County Government or State Government) or look for your local DHS office online at www.michigan.gov/dhs. DHS will send you an application, or it can be found and printed online at **www.michigan.gov/dhs**.

Q. I lost my job and I'm getting COBRA coverage, but it's very expensive. Will I be able to get less expensive coverage through health care reform?
If you are getting COBRA coverage, you may find that there are already lower-cost individual health insurance options available to you through HAP.

Starting in 2014, health care reform will include lower costs for low- and middle-income individuals who qualify based on their income and family size. Lower costs will be available only through the new Health Insurance Marketplace, which will offer a wide variety of health plans, including HAP plans to fit your budget. If your COBRA coverage runs out or if you choose to end it, you will be able to change from COBRA coverage to Health Insurance Marketplace coverage at any time, even if it's not during the annual open enrollment period.

Q. Under health care reform, who is going to be making decisions about the care I need?
As is now the case, you will be able to choose from a wide variety of private health plans, and decisions about your care will be made by you and your doctor.

The Affordable Care Act guarantees your right to appeal a health plan decision. Private insurance plans have to tell you why a claim has been denied and they have to let you know how you can dispute their decision.

Q: What can I do today to get ready for the changes coming in 2014?
Open enrollment starts October 1, 2013 for coverage starting as soon as January 1, 2014. But you don't have to wait until open enrollment to learn more about your options and start thinking about what matters most to you and your family. Visit **chooseHAP.org** to learn more.

Health Alliance Plan

HAP Personal Alliance (HMO) is offered through Health Alliance Plan, a state-certified Health Maintenance Organization.

HAP Personal Alliance is offered through Alliance Health and Life Insurance Company, Inc. (Alliance), a wholly owned subsidiary of Health Alliance Plan.

chooseHAP.org

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