# 9 Things You Need to Know About the Affordable Care Act

*Find out what health care reform means for you*

Arise HEALTH PLAN

# Health care reform law is reinventing the health insurance business

The Affordable Care Act (ACA), passed in March of 2010 and upheld by the Supreme Court of the United States in June of 2012, has been making headlines for the past few years. Today, it's dramatically changing the way health insurance is provided to Americans. This piece of legislation serves up all kinds of new rules about how health insurance affects health care providers, insurers, and consumers like you now and in coming years.

This guide contains information that may help you navigate through the new rules. **It is intended for informational purposes only and should not be considered legal advice.** The information is not specific to Arise policies, but rather intended as general educational material; actual plan details may vary. For detailed information and guidance related to the Affordable Care Act, please talk to your health insurance agent/broker or your Arise representative. In the emerging health care reform era, your agent is likely to become an even more important resource. You can also refer to www.healthcare.gov (the official website for health care reform set up by the U.S. Department of Health and Human Services), your attorney, or your accountant.

Even though ACA brings a lot of change to health insurance, the reasons for having health insurance in the first place remain the same.

- Insurance companies negotiate prices with service providers, such as doctors and hospitals, which means you get a better deal on your health care.
- Health care costs are the leading cause of bankruptcies. Having insurance can protect your savings if a major medical emergency were to happen to you.
- Studies show that insured people are generally healthier than uninsured people. Why? Because they're more likely to see the doctor regularly, which helps prevent problems and treat existing health issues better.

# 1. Individual responsibility gets everyone in the pool

The individual responsibility clause, also called the individual mandate, included in the Affordable Care Act (ACA) goes into full effect in 2014. It requires almost everyone in the U.S. to have health insurance or pay a penalty tax, also called an assessment. The idea behind this requirement is to get as many people as possible—young, old, men, women, healthy, sick—into the insurance pool so that the risk is manageable for insurance companies and coverage can remain affordable.

Without this clause, the balance needed to provide affordable health insurance for everyone takes an unfavorable tip. If healthy people abstain from insurance and only sick people seek coverage, then insurance costs spiral out of control as insurers, who in 2014 can no longer deny anyone coverage, are forced to raise premiums to pay claims.

## Who is affected by this mandate?

More than half of Americans who have private insurance are covered through their employers.[1] A total of 64% of people had private insurance in 2010, while 31% had government health insurance, such as Medicare and Medicaid.

The good news here is that most people have coverage and don't need to worry about the individual responsibility aspect of ACA at all. And most people who have insurance will be able to keep it. However, there will be some instances where existing health plans fail to meet the coverage requirements of ACA and must be changed (with a corresponding increase in rates) or dropped. Also, employers will have to take a look at their circumstances and decide whether to add, drop, or continue offering coverage.

The people most affected by the individual responsibility clause are those who are not insured. In 2010, about 16% of Americans carried no insurance. Those 49.9 million people are the ones who need to get coverage or risk paying the penalty tax.

## Insurance options

So what counts as insurance to keep you safe from the possibility of the penalty tax? You need to be insured for the whole year through one of the following sources:[2]

- Medicare
- Medicaid or the Children's Health Insurance Program (CHIP)
- TRICARE, which is for service members, retirees, and their families
- The veteran's health program
- A plan offered by an employer
- An individual health insurance plan that is at least at the "bronze" level (see section 3 on exchanges for an explanation of the bronze level)
- A grandfathered health plan in existence before the ACA was enacted
- A government-sponsored health program
- A state health benefits risk pool plan

## Penalty tax

If you choose to forego insurance, you may have to pay a penalty tax. The Internal Revenue Service (IRS) is charged with collecting it from you. When you file your taxes, if you have a gap in coverage for a continuous three-month period or more during the previous year, the IRS will take the penalty tax money out of your tax refund or add it to what you owe.

What will the penalty tax cost you? It depends on the year. The chart below lists the annual totals that may be assessed.

### Penalty tax amounts[2]

| 2014 | 2015 | 2016 and beyond |
|---|---|---|
| $95 per adult and $47.50 per child (up to $285 per family) OR 1.0% of family income, whichever is greater | $325 per adult and $162.50 per child (up to $975 per family) OR 2.0% of family income, whichever is greater | $695 per adult and $347.50 per child (up to $2,085 per family) OR 2.5% of family income, whichever is greater |

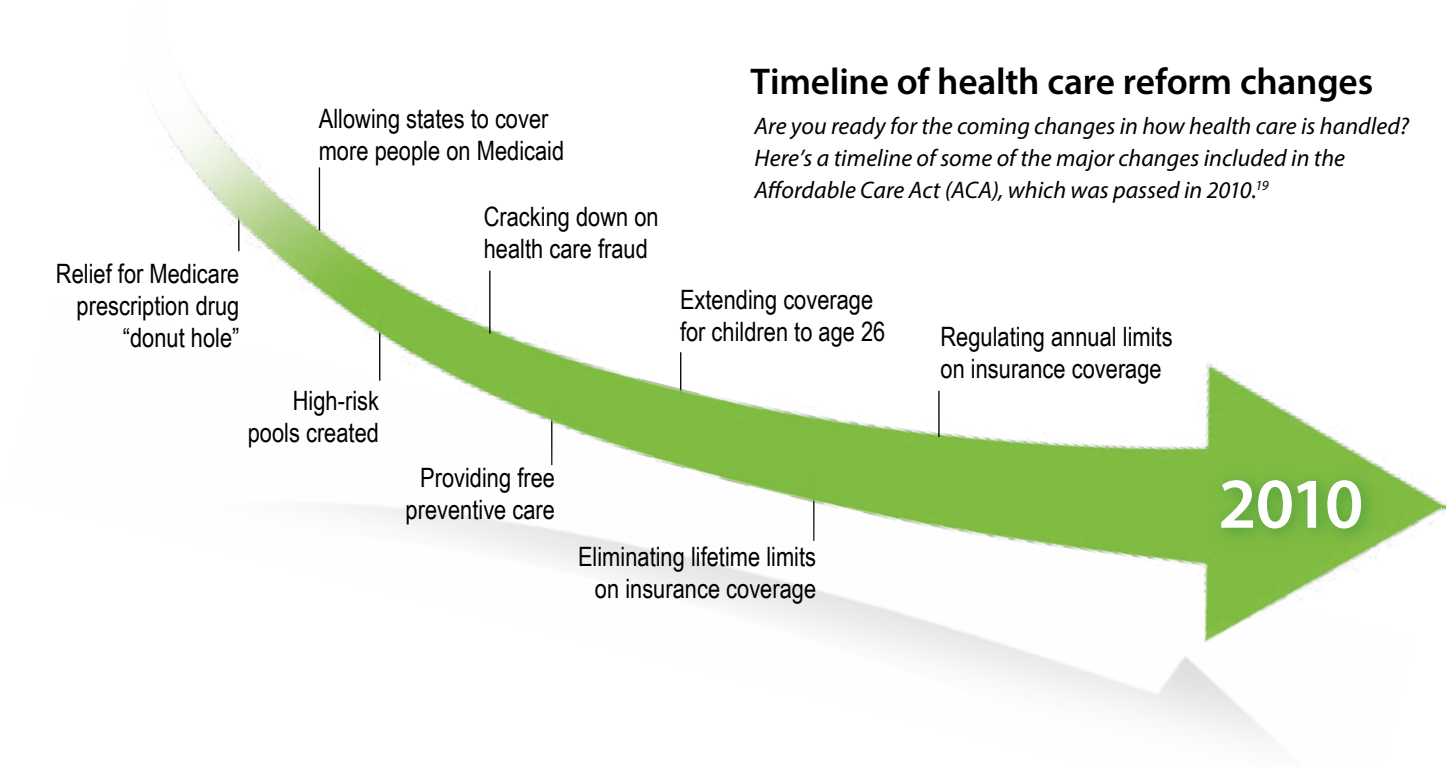
You may be able to avoid the penalty tax if you meet one of the following requirements:[2]

- You are part of a religion opposed to acceptance of benefits from a health insurance policy.
- You are an undocumented immigrant.
- You are incarcerated.
- You are a member of certain Native American tribes.
- Your family income is below the threshold requiring you to file a tax return ($9,350 for an individual in 2010; $18,700 for a family in 2010).
- You have to pay more than 8% of your income for health insurance, after taking into account any employer contributions or tax credits.
- You have a gap in coverage for less than a continuous three-month period (this exemption may only be used for one period without coverage in a year).

What do you do if you can't afford health insurance? You may qualify for a subsidy from the federal government. See section 5 for more information on subsidies.

### Timeline of health care reform changes

*Are you ready for the coming changes in how health care is handled? Here's a timeline of some of the major changes included in the Affordable Care Act (ACA), which was passed in 2010.[19]*



# 2. Guaranteed issue means you can't be denied

Guaranteed issue means that anyone can purchase a health plan regardless of health status or other factors.[18]

Today, eligibility for people seeking individual health plans is based, in part, on medical factors. However, this is not the case for those participating in group health plans. People may be denied an individual health plan for a variety of pre-existing conditions, such as cancer and other chronic ailments.

The Affordable Care Act (ACA) changes that. It requires insurance companies to insure anyone who applies. However, this change is being phased in. On Sept. 23, 2010, pre-existing condition limitations were removed for children younger than 19. Beginning on Jan. 1, 2014, most individual and group health plans must provide coverage to all applicants. This provision applies to all group plans and new individual plans, but not to grandfathered individual plans in existence prior to Mar. 23, 2010.

In the past, coverage could be rescinded for incorrect information about your health history submitted on your application. A rescission* declares your policy invalid from the day it started. If you incurred claims for medical care, you may be responsible for covering those costs.

Since Sept. 23, 2010, ACA has limited rescissions to cases of fraud or intentional misrepresentation of fact. This means that your policy can't be rescinded for a mistake made by you or your employer. However, it can still be rescinded if you intentionally put false or misleading information on your application. Also, insurance companies can still cancel your policy if you don't pay your premium.

So if you have health problems that have prevented you from getting coverage in the past, you'll be able to get the coverage you need from an insurance exchange or through a health insurance company in 2014 without any worries.

*See glossary on page 13.

# 3. Health insurance premiums may change

Beginning in 2014, insurance companies must provide coverage to anyone who applies. The Affordable Care Act (ACA) sets limits on how much a person can be charged so that one group of people isn't charged excessively compared to another group.[3] This means that rates will likely change.

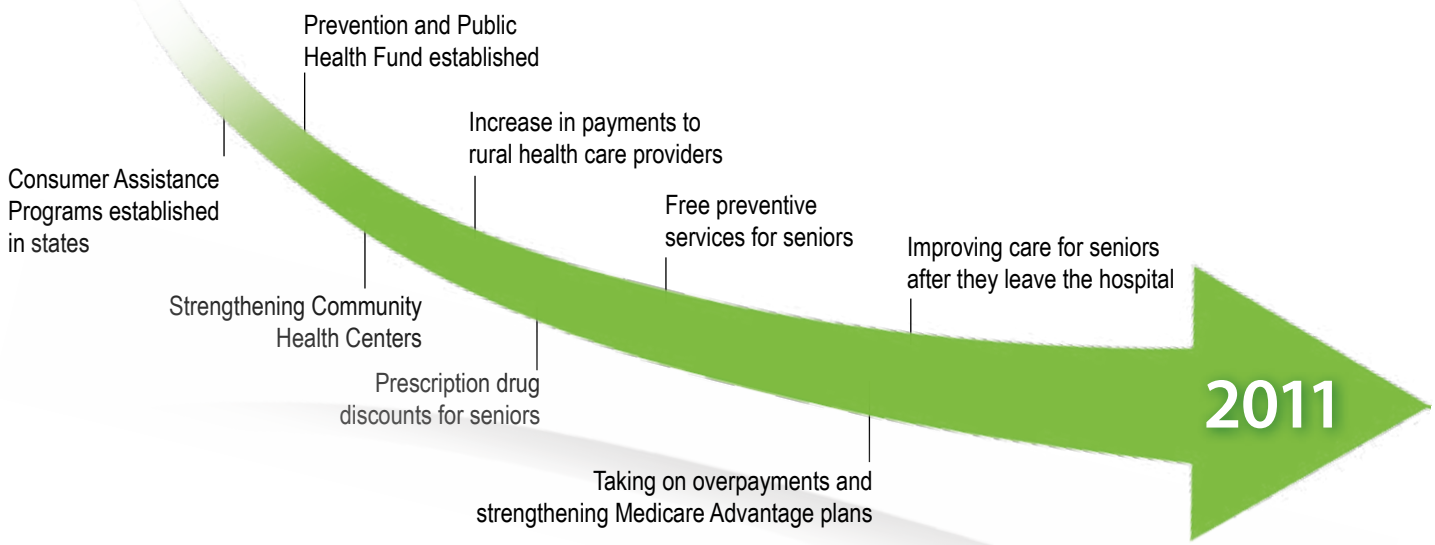
Today, federal law doesn't place any limits on how insurance companies set their premiums. The ACA changes this starting Jan. 1, 2014. Under the ACA rules, health plans can only adjust premiums based on these factors:

- **Individual vs. family enrollment.** Rates can vary based on who is enrolled in the plan. For example, an individual rate might be different than a rate for an individual and his spouse or an individual and all of his dependents.
- **Geographic area.** Health plans may cost more for people who live in areas where medical costs are high.
- **Age.** Rates can vary depending on age, but are limited by a 3:1 ratio. Older adults cannot be charged more than three times the rate of a younger person.
- **Tobacco use.** Insurance companies can charge tobacco users more. However, those who use tobacco products cannot be charged more than 1.5 times the normal rate.

Starting in 2014, the major factors that insurance companies use today to calculate premiums will no longer be allowed. So your health status (including pre-existing conditions; see section 2 on guaranteed issue), use of health services, and gender cannot be used to adjust your premium. One note here is that employment-based health plans will be allowed to charge workers up to 30% more on their premiums if those employees don't participate in a wellness program or meet specified health goals.

Because of these limits, rates for insurance plans will likely increase for most people.[4] However, the rates may no longer vary as widely as they do today.[5] As premiums come into step with the new regulations, some who previously had higher premiums may see some relief while most populations that had lower premiums may see increases. For example, older people may see slight decreases in their premiums. Younger, healthier people ages 21 to 29—men especially—may see overall rate increases of as much as 42%.[4]

The ACA restrictions are a minimum, so states are free to use them or enact even tougher standards of their own.



# 4. Exchanges will offer another way to shop for health insurance

Beginning Oct. 1, 2013, individuals and small businesses can shop for health plans that go into effect on Jan. 1, 2014 through insurance exchanges* in each state. People will still be able to purchase insurance directly from an insurance company or through a broker. Exchanges will simply offer a new option. They are intended to increase the size of the insured pool to spread out risk and keep costs stable.

Exchanges are designed to simplify shopping for and buying insurance. They will offer consumers information on the quality of health plans. They won't sell plans that fail to meet minimum quality standards and benefit packages (see section 6 on essential health benefits) set by the federal government.

They'll group health plans into tiers—bronze, silver, gold, and platinum—based on how much of the cost customers take on. The Affordable Care Act (ACA) also requires insurers to justify annual price increases to the exchange board.

ACA ordered states to create exchanges, which may be set up as state agencies, independent governmental entities or nonprofits. As of May 2013, 16 states plus the District of Columbia have established exchanges, seven are planning for a partnership exchange, and 27 have decided not to create a state exchange and default to a federal exchange.[6]

## Exchange plans[7]

| Plan category | Benefits |
|---|---|
| **Bronze** | Minimum creditable coverage. Provides essential health benefits. Covers 60% of costs with an out-of-pocket limit equal to the HSA law limit ($6,250 for individuals, $12,500 for families in 2013). |
| **Silver** | Provides essential health benefits. Covers 70% of costs with an out-of-pocket limit equal to the HSA law limit. |
| **Gold** | Provides essential health benefits. Covers 80% of costs with an out-of-pocket limit equal to the HSA law limit. |
| **Platinum** | Provides essential health benefits. Covers 90% of costs with an out-of-pocket limit equal to the HSA law limit. |
| **Catastrophic** | Restricted to individual market only. Available to those up to age 30 or who are exempt from the mandate to purchase coverage. Provides catastrophic coverage with the coverage level set at the current HSA law levels, except that preventive benefits and coverage for three primary care visits are exempt from the deductible. |

*See glossary on page 13.

**FAST FACT** The online marketplaces called "exchanges" will allow apples-to-apples comparisons of health insurance plans.

# 5. Subsidies will help struggling Americans afford health insurance

Beginning in 2014, if you are a single person making less than $44,680 annually (in 2012 dollars) or have a family of four that makes less than $92,200 per year (in 2012 dollars), and your employer doesn't offer affordable coverage, you may be able to get some help paying for your health insurance premium.[8]

Tax credits from the federal government will be available for people whose income is between 100 and 400% of the federal poverty level who are not eligible for other affordable coverage (through an employer, for example). The credits are based on insurance plans at the "silver" level in the area where a person lives. For insurance at a higher level, the insured will have to pay the additional cost.[9] Subsidies must be used for health plans purchased through the exchange.

The tax credit is "advanceable," which means that instead of waiting for tax time to get your money in a lump sum, it can be "advanced" to you so you can lower your insurance premium each month. You don't have to pay and then wait to be reimbursed. The tax credit is available as soon as you enroll in a plan. It can be paid directly to your insurance company to offset your premium. The tax credit, unlike a tax deduction, reduces the amount of tax you owe dollar for dollar.

The Affordable Care Act (ACA) states that people earning 133% of the federal poverty level or less are not eligible for these tax credits, but are instead eligible for Medicaid. However, in Wisconsin, the state legislature and the governor chose not to expand Medicaid, also known as BadgerCare Plus, to this level.[10] Lawmakers instead reduced eligibility for Wisconsin's Medicaid program from 200% to 100% of the poverty level and added eligibility for childless adults.

The remaining 33% of Wisconsin residents above the 100% threshold are eligible for tax credits. They, like other subsidized insurance shoppers, must get their health insurance through the state's health insurance exchange to take advantage of them. Low-income children are eligible for the Children's Health Insurance Program (CHIP). People can apply for Medicaid or CHIP right now without waiting for the exchanges to open.

## Tax credits[8]

| *Estimates are 2014 projected annual costs for a person in a medium-cost region.* | | | | | |
|---|---|---|---|---|---|
| **Percent of federal poverty level** | **Income range (in 2014 dollars)** | **Health insurance premium (adjusted for age)** | **Maximum % of income for the premium** | **Actual required premium payment** | **Government tax credit** |
| **Single person (based on 30-year-old nonsmoker)** | | | | | |
| 100–133% (in states that did not expand Medicaid) | $11,490–$15,281 | $3,426 | 2% | $230–$306 | $3,196–$3,120 |
| 134–150% | $15,396–$17,235 | $3,426 | 3.06–4.00% | $471–$689 | $2,955–$2,736 |
| 151–200% | $17,349–$22,980 | $3,426 | 4.05–6.30% | $702–$1,448 | $2,724–$1,978 |
| 201–250% | $23,094–$28,725 | $3,426 | 6.33–8.05% | $1,463–$2,312 | $1,963–$1,113 |
| 251–300% | $28,839–$34,470 | $3,426 | 8.08–9.50% | $2,330–$3,275 | $1,096–$151 |
| 301–400% | $34,584–$45,960 | $3,426 | 9.50% | $3,285–$3,426 | $140–$0 |
| **Family of 4 (based on two 30-year-old nonsmokers with two children)** | | | | | |
| 100–133% (in states that did not expand Medicaid) | $23,550–$31,321 | $10,684 | 2% | $471–$626 | $9,806–$9,650 |
| 134–150% | $31,557–$35,325 | $10,684 | 3.06–4.00% | $965–$1,413 | $9,719–$9,271 |
| 151–200% | $35,560–$47,100 | $10,684 | 4.05–6.30% | $1,439–$2,967 | $9,245–$7,717 |
| 201–250% | $47,335–$58,875 | $10,684 | 6.33–8.05% | $2,999–$4,739 | $7,685–$5,945 |
| 251–300% | $59,110–$70,650 | $10,684 | 8.08–9.50% | $4,775–$6,712 | $5,909–$3,972 |
| 301–400% | $70,885–$94,200 | $10,684 | 9.50% | $6,734–$8,949 | $3,950–$1,735 |
| Note: Costs for Wisconsin residents will likely be higher and rates will vary significantly by age. | | | | | |

Those who qualify for tax credits may also qualify for reduced cost sharing to reduce their out-of-pocket costs.[9] People whose incomes are up to 250% of the poverty level may be able to take advantage of reduced cost sharing for copays, coinsurance, and other expenses. When you apply for coverage through the exchange, you'll find out if you're eligible for these savings.[11] If you're eligible, you must choose a silver plan to get the cost-sharing savings.

If your employer does not offer coverage, or if it's too expensive, you can find consumer help online at www.healthcare.gov.

# 6. No more limits on essential health benefits

Today, most health plans have limits on how much coverage you get. By 2014, that will no longer be the case for essential health benefits.* The Affordable Care Act (ACA) requires your plan to cover your costs for essential health benefits so that you'll have the coverage you need. This applies to individual insurance and group insurance that you get either on your own or through your employer.

Essential health benefits include items and services within at least the following 10 categories:[12]

- 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
- Pediatric services, including oral and vision care.

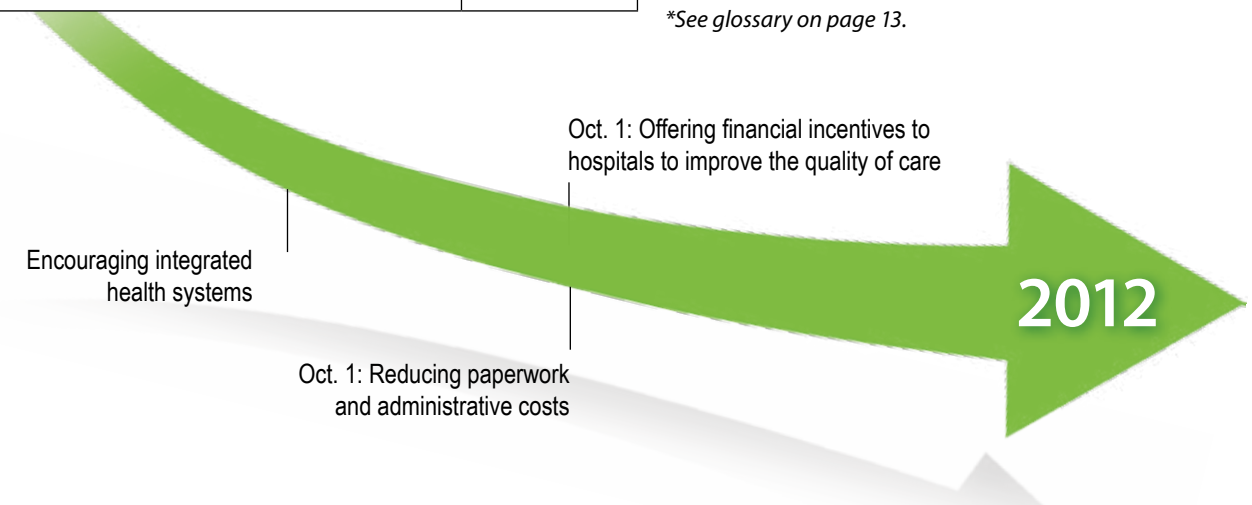
One provision that went into effect on Sept. 23, 2010 eliminates lifetime limits* on coverage. Any new policy issued after that date is considered not grandfathered and cannot have a lifetime limit.

Annual limits* are being phased out over a period of years. See the chart.

| Time period | Annual limit |
|---|---|
| On or after Sept. 23, 2010 but before Sept. 23, 2011 | $750,000 |
| On or after Sept. 23, 2011 but before Sept. 23, 2012 | $1.25 million |
| On or after Sept. 23, 2012 but before Jan. 1, 2014 | $2 million |
| Beginning Jan. 1, 2014 | None |

Keep in mind, though, that health plans can still impose annual and lifetime limits on coverage that isn't considered "essential," such as acupuncture and some chiropractic treatments, depending on which state you live in. And while plans cannot put limits on the dollar amounts, there may be limits on how many office visits are covered.

*See glossary on page 13.*



# 7. Preventive care is 100% covered

Under the Affordable Care Act (ACA), preventive care must be covered by insurance plans 100%. Preventive care helps keep people healthier and reduces health care expenses in the long term.

As a consumer, it's important to remember that there's a difference between "preventive" care and "diagnostic" care. Your preventive care is covered, but if your doctor wants to examine any specific health issues further, that falls in the "diagnostic" category, which means you'll likely be paying a copay or coinsurance.

## Preventive care coverage requirements for health insurance plans beginning on or after Sept. 23, 2010[13]

### ADULTS

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Aspirin use
- Blood pressure screening
- Cholesterol screening for certain ages or at higher risk
- Colorectal cancer screening for people age 50 or older
- Depression screening
- Type 2 diabetes screening for people with high blood pressure
- Diet counseling for people at higher risk of chronic disease
- HIV screening for people at higher risk
- Immunization vaccines
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling for people at higher risk
- Tobacco use screening and cessation interventions
- Syphilis screening for people at higher risk

### WOMEN

- Anemia screening during pregnancy
- Bacteriuria urinary tract or other infection screening during pregnancy
- BRCA counseling about genetic testing for women at higher risk
- Breast cancer mammography screenings for age 40 and older
- Breast cancer chemoprevention counseling for women at higher risk
- Breastfeeding support and counseling plus access to breastfeeding supplies
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and others at higher risk
- Contraception and patient education and counseling
- Domestic and interpersonal violence screening and counseling
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant
- Gonorrhea screening for women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- HIV screening and counseling
- HPV DNA test every three years for women with normal cytology results who are age 30 and older
- Osteoporosis screening for women older than 60
- Rh incompatibility screening for pregnant women
- Tobacco use screening and intervention; expanded counseling for pregnant tobacco users
- Sexually transmitted infections (STI) counseling for sexually active women
- Syphilis screening for pregnant women and women at increased risk
- Well-woman visits for preventive services for women under 65

## CHILDREN

- Alcohol and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments
- Blood pressure screening
- Cervical dysplasia screening for sexually active females
- Congenital hypothyroidism screening for newborns
- Depression screening for adolescents
- Developmental screening for children under age 3
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride chemoprevention supplements
- Gonorrhea preventive medication for newborns' eyes
- Hearing screening for newborns
- Height, weight, and body mass index measurements for children
- Hematocrit or hemoglobin screening
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines
- Iron supplements for babies age 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical history
- Obesity screening and counseling
- Oral health risk assessment for children up to age 10
- Phenylketonuria (PKU) screening for newborns
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing
- Vision screening

New health plans issued on or after Aug.1, 2012 must also comply with these additional preventive care requirements for women.[14] They include:

- Well-woman visits
- Gestational diabetes screening
- Domestic and interpersonal violence screening and counseling
- FDA-approved contraceptive methods, and contraceptive education and counseling
- Breastfeeding support, supplies, and counseling
- HPV DNA testing for women age 30 and older
- Sexually transmitted infections counseling for sexually active women
- HIV screening and counseling for sexually active women

Preventive care is covered under every level of health insurance on the exchanges. Even catastrophic-level policies cover preventive care. See section 4 for more information on exchanges.

# 8. Children are covered until age 26

Sometimes it's hard to get them out of the nest. But whether they live with you or not, your children can get coverage under your insurance policy if a couple of conditions are met.[15]

First, your policy has to allow dependent coverage. That means you need a family health plan.

Second, if your insurance is through your employer, your child must not have access to his own job-based insurance. That is, he must be a student, unemployed, or work where insurance isn't offered. If he's got a job and can get insurance through his employer, he must choose that option. However, this limitation goes away in 2014. If both of these criteria are met, your child can be covered by your policy until he turns 26—even if he's married, financially independent, or not living with you. Once he's 26, though, he's off your policy for good.

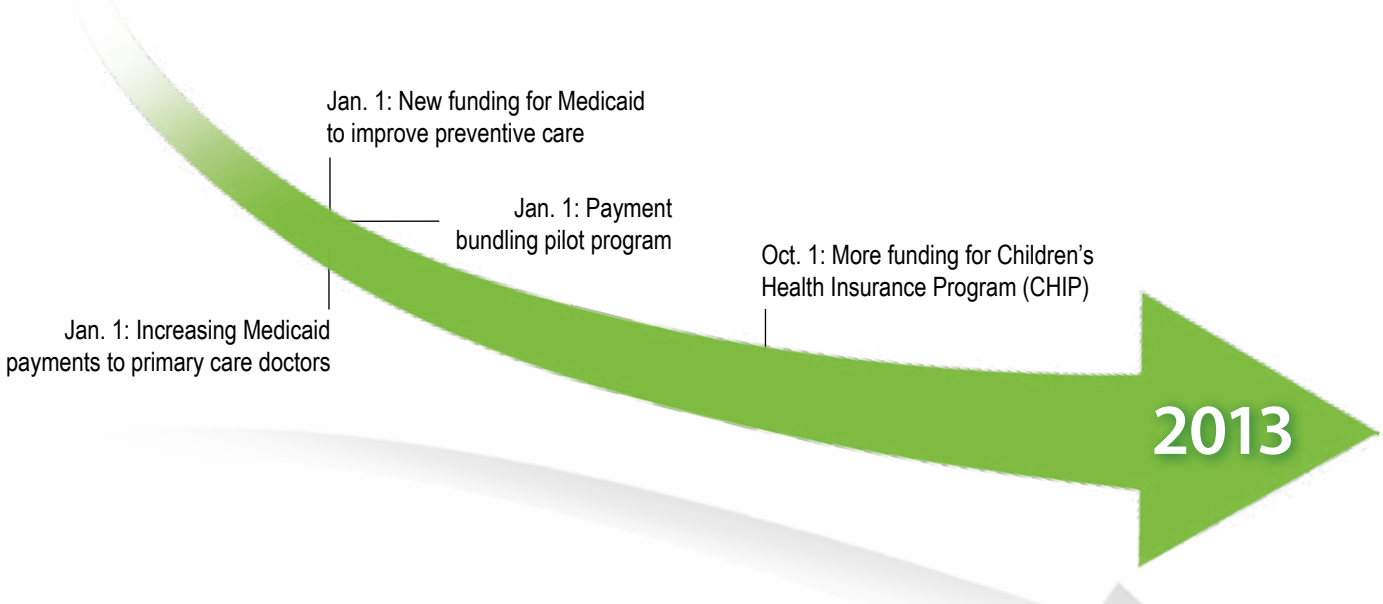
# 9. How and when to sign up for a health plan

The Affordable Care Act (ACA) created health insurance marketplaces, or exchanges (see section 4), to make it easier for people to compare and shop for insurance. It also facilitated the creation of new helpers—which may be called navigators*, application assistors, or certified application counselors, depending on who provides the service and where they are located—to help people get through the process. Why? Because health insurance can be hard to understand and everyone's situation is different.

## Who can help

Navigators don't work on commission, can't favor any one insurance company, and can't be paid by any insurance company.[16] Their job is to educate consumers and help them apply for health insurance. They can provide impartial information and guidance, but cannot tell consumers which plan to choose. Navigators may be self-employed or may belong to certain groups, such as unions, church groups, tribal organizations, and chambers of commerce. Insurance agents, as they have for many years, can still help people select the health plan that's best for each situation. As licensed insurance professionals, they are allowed to recommend plans, setting them apart from navigators.

*See glossary on page 13.



## How to sign up

People shopping for insurance can apply for a health plan through the state exchange by going online, using paper forms, or picking up the phone. The exchange website for each state will walk users through the process, step by step. Consumers will be able to save their progress so they can quit at any point and come back later to finish.

If you have questions before or after the exchanges open, you can call the Healthcare.gov call center at 1-800-318-2596 (TTY: 1-855-889-4325) anytime, 24 hours a day. The website also offers a live chat service; visit www.healthcare.gov/help-center.

## When to sign up

Open enrollment begins on Oct. 1, 2013, for health plans effective Jan. 1, 2014.[17] This first enrollment period runs until March 31, 2014. After that, the annual open enrollment period will be from Oct. 15 to Dec. 7.

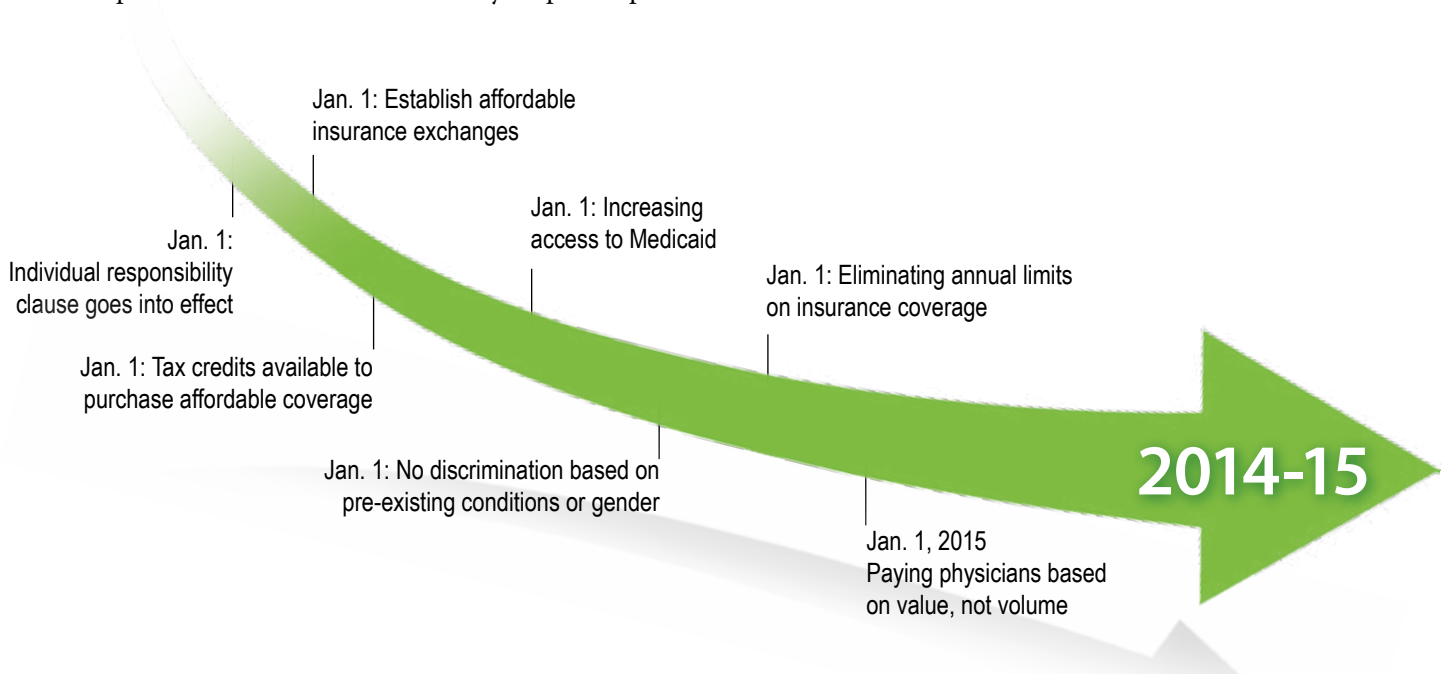
If you enroll in a health plan between Oct. 1, 2013, and Dec. 15, 2013, and make your first premium payment, your new health coverage starts Jan. 1, 2014.

During the rest of open enrollment, if you enroll between the 1st and 15th day of the month and pay your premium, your coverage begins the first day of the next month. So if you enroll on Feb. 10, 2014, your coverage begins March 1, 2014.

If you enroll between the 16th and the last day of the month and pay your premium, your effective date of coverage will be the first day of the *second* following month. So if you enroll on Feb. 16, 2013, your coverage starts on April 1, 2014.

**Consumers can only purchase health insurance coverage during the annual open enrollment period** unless they have a special enrollment or limited enrollment event. Those events include a marriage, birth or adoption, the loss of other coverage due to job loss, becoming newly eligible for advanced payments of the premium tax credit, and moving to a new coverage area. If the exchange navigators determine a person was incorrectly or inappropriately enrolled in some other type of coverage, then that may also trigger a special enrollment event.

In 2014, there will also be a one-time open enrollment period so that individuals with non-calendar-year plans can transition to calendar-year plans upon their renewal dates in 2014.



# Glossary of terms[20]

**Annual limit:** A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. These caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

**Essential health benefits:** A set of health care service categories that must be covered by certain plans starting in 2014. The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the exchanges, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Insurance policies must cover these benefits in order to be certified and offered in Exchanges, and all Medicaid state plans must cover these services by 2014.

**Exchange:** A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Exchanges will offer you a choice of health plans that meet certain benefits and cost standards. Starting in 2014, members of Congress will be getting their health care insurance through exchanges and you will be able buy your insurance through exchanges too.

**Lifetime limit:** A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like a $200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

**Navigators:** An individual or organization that's 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 be unbiased. Their services are free to consumers.

**Rescission:** The retroactive cancellation of a health insurance policy. Under the Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

# Sources

[1]United States Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2010 (September 2011). Retrieved from http://www.census.gov/prod/2011pubs/p60-239.pdf

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**HSA-qualified high-deductible health plan (HDHP)** options are also available for both the POS and HMO plans. They give you the option of controlling your health care expenses more directly using a health savings account (HSA), which acts like a personal savings account and allows you to pay for qualified medical bills using tax-free funds.

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