EMPLOYEE BENEFITS GUIDEBOOK

2020

ALLEN HEALTH - LOCAL 389 HEALTH BENEFIT FUND

HOME CARE EMPLOYEES LOCAL 389

Elara Caring

DC37 AFSCME AFL-CIO

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WELCOME

Dear Allen Health – Local 389 Member,

We are proud to present your benefit program provided by the Allen Health – Local 389 Health Benefit Fund. This booklet is designed as a summary of the benefits available to participants. Depending upon your hours of service, you will be eligible for one or both of these levels of coverage:

- Health Insurance – Empire Blue Cross Blue Shield EPO – Minimum of 300 paid hours during initial and standard measurement periods of 3 calendar months. This program will require an employee contribution of $4.00 per week for the employee only. Coverage is available for dependents at a higher rate of contribution.
- Dental & Vision Eligibility - Only HHAs electing health insurance will receive this benefit
- Transit - 130 hours per calendar quarter, no Employee cost
- EAP - 65 hours per calendar quarter.

Please take a moment to review the program. You will note that there is also information regarding low cost, or zero cost coverage options through Medicaid and Child Health Plus,

should you qualify.

IF YOU DO NOT WISH TO CONTINUE THE HEALTH COVERAGE, PLEASE CONTACT ALLEN HEALTHCARE'S HUMAN RESOURCES DEPARTMENT AT (718) 657-2966.

If you have questions regarding your eligibility for Health Insurance, Dental or Vision eligibility, please contact Boon Group at (866) 868-8310.

Sincerely,
Allen Health - Local 389 Health Benefit Fund

MEDICAL PLAN EMPIRE

Empire BlueCross BlueShield
An Anthem Company

ELIGIBILITY

Available to Employees working a minimum of 300 hours or more during initial and standard measurement period of 3 calendar months. If you sign up for the medical, you are automatically enrolled in dental and vision.

PLAN YEAR: 3/1/2020 to 2/28/2021

COVERAGE SUMMARY	BLUE CHOICE NETWORK
	IN-NETWORK:
Out of Pocket Limit on Expenses	$6,000 Individual $12,000 Family
Deductible	$0
Coinsurance	0%
Preventive Care	$0 Co-Payment Per Visit
Physicians Office Visits	$25 Co-Payment
Specialist Office Visits	$40 Co-Payment
Lab Services Complex Imaging (MRI, MRA, PET, CAT Scans, etc.)	Lab: $0 | Office: $25 $0
Emergency Room	$150 Co-Payment waived if admitted
Urgent Care	$25 Co-Payment
Durable Medical Equipment	$40 Co-Payment
Hospital Inpatient Care	$100/day (up to 3 days)
Hospital Outpatient Care	$100 Facility Fee | $0 Surgeon Fee

PRESCRIPTION DRUG CARD			
	Generic	Preferred	Non-Preferred
Retail 30 Day Supply	$10	$25	$50
Mail Order 90 Day Supply	$20	$50	$100

DENTAL PLAN OPTION

Empire BlueCross BlueShield
An Anthem Company

ELIGIBILITY

When you sign up for the medial plan, you are automatically enrolled in the dental plan. Dental is only available when electing medical.

PLAN YEAR: 3/1/2020 to 2/28/2021

DENTAL PLAN	PPO	
CALENDAR YEAR DEDUCTIBLE	IN-NETWORK	OUT-OF-NETWORK
Individual	$75	$75
Family limit (EE +1 or more)	$225	$225
CHARGES COVERED FOR YOU (co-insurance)	IN-NETWORK	OUT-OF-NETWORK
Preventive Care ▸ Full mouth x-rays ▸ Sealants	100%	100%
Basic Care ▸ Fill-ins ▸ Simple Extractions ▸ Anesthesia	50%	50%
Major Care	50%	50%
▸ Crowns/Dentures/Bridges		
▸ Periodontal surgery		
▸ Root canal		
▸ Implants		
Orthodontia	Not covered	Not covered
ANNUAL MAXIMUM BENEFIT	$750 plus max rollover	$750 plus max rollover

VISION PLAN OPTION

Empire BlueCross BlueShield
An Anthem Company

ELIGIBILITY

When you sign up for the medial plan, you are automatically enrolled in the vision plan. Vision is only available when electing medical.

PLAN YEAR: 3/1/2020 to 2/28/2021

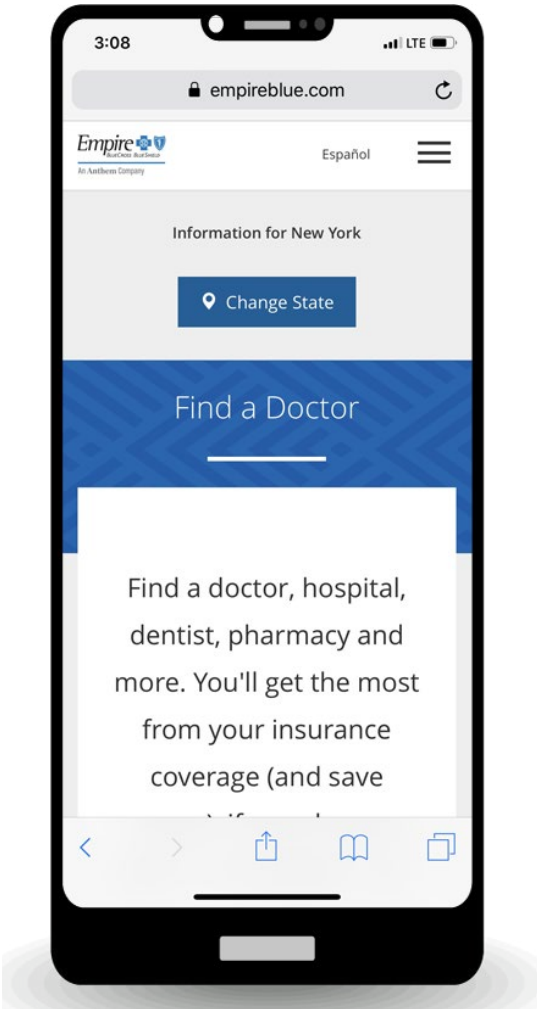
VISION PLAN	IN NETWORK	OUT OF NETWORK
COPAYS		
Exam	$0	$50 allowance
Frames	$120 allowance + 20% off balance	$48 allowance
BENEFIT FREQUENCY		
▸Exam	12 months	
▸Lenses	12 months	
▸Frames	24 months	
▸Contact Lenses	12 months in lieu of lenses and frames	
	IN NETWORK	**OUT OF NETWORK**
EXAM	$0 Co-payment	
LENSES		
▸Single Vision	$0 Co-payment	$48
▸Bifocal		$67
▸Trifocals		$86
CONTACT LENSES		
▸Elective	$120 allowance (Co-payment waived)	$105 max (Co-payment waived)
▸Necessary	Covered in full	$210 allowance

FIND A PROVIDER

Empire BlueCross BlueShield
An Anthem Company

STEP 1

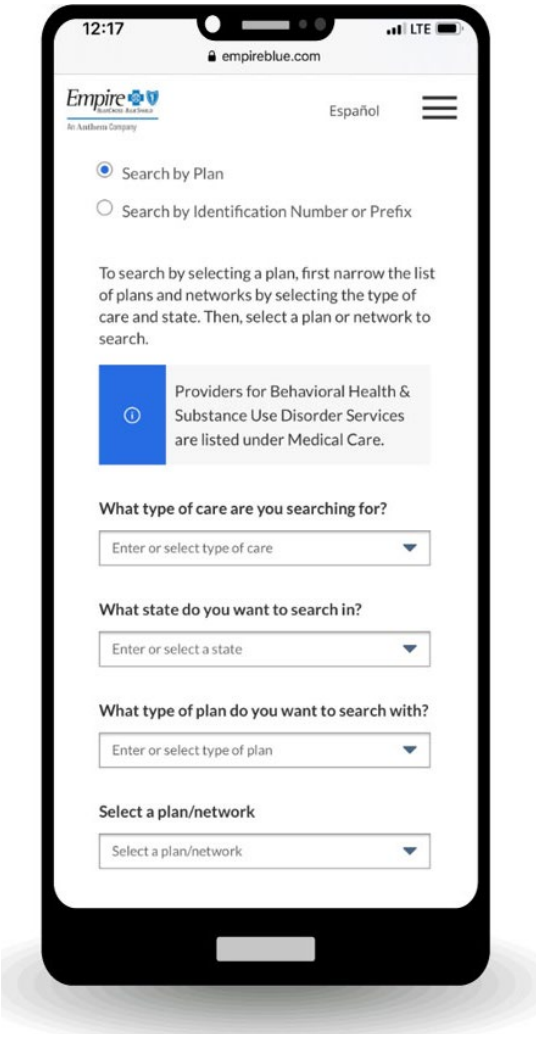
Visit *empireblue.com/findadoctor*
(or visit empireblue.com,
click menu and then click Find a Doctor)
Search as a Guest (scroll down)



STEP 2

If searching as guest, complete the following fields:

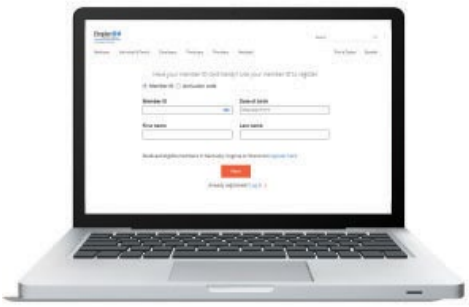
- What type of care are you searching for? *Medical/Dental/Vision*
- What state do you want to search in? *Select a state*
- What type of plan do you want to search with? *Medical/Dental/Vision*
- Select plan/network?
  - Medical *Blue Access (Employer-Sponsored)*
  - Dental *Dental Complete*
  - Vision *Blue View Vision*



FIND A PROVIDER

Empire BlueCross BlueShield
An Anthem Company

Register on empireblue.com or the Sydney mobile app.*
Have your member ID card handy to register



FROM YOUR COMPUTER

- Go to *empireblue.com/register*
- Provide the information requested
- Create a username and password
- Set your email preferences
- Follow the steps to complete your registration

FROM YOUR PHONE/TABLET

- Download the free *Sydney* mobile app and select *Register*
- Confirm your identity
- Create a username and password
- Confirm your email preferences
- Follow the steps to complete your registration

MASS TRANSPORTATION

Clarity BENEFIT SOLUTIONS

Requires 130 or more hours per calendar quarter for this benefit
PLAN YEAR: 3/1/2020 to 2/28/2021

Features: Allen Health - Local 389 Health Benefit Fund offers a commuter benefits program through Clarity Benefit
Solutions that can save you time and money on your commute.

- No completion of claim forms
- No out of pocket expenses
- No waiting for reimbursement

Debit Card Issuance Fee (One Time):
Paid for by Allen Health - Local 389 Health Benefit Fund
(Lost/replacement cards: $2.00 each)

Transit Benefit Amount: $130 per calendar quarter

EMPLOYEE ASSISTANCE PROGRAM

ComPsych®
The GuidanceResources Company®

65 hours per calendar quarter
PLAN YEAR: 3/1/2020 to 2/28/2021

Features: The Allen Health - Local 389 Health Benefit Fund Benefits Program offers you and your family access to an Employee Assistance Program (EAP) through ComPsych's partnership with Guidance Resources. This program is provided at no cost to you and your family. The EAP provides confidential help with a wide variety of personal and work concerns such as stress, parenting, substance abuse, relationship, family and financial issues. The EAP offers you and your family the following benefits and services 24-hours a day, seven days a week, 365 days a year:

- Confidential Counseling
- Legal Support Resources
- Financial Information & Resources
- Work-Life Situations
- Guidance Resources Online
- Free Online Will Preparation

ANNUAL PHYSICALS AT NO COST

65 hours per calendar quarter
PLAN YEAR: 3/1/2020 to 2/28/2021

Mobile Health's occupational health services include packaged health physicals which include a physical exam, tuberculosis test, any vaccination or titers required, and any other procedures needed by the employer.

Employee physicals are available at all of Mobile Health's six medical centers located in Manhattan, Bronx, Brooklyn, Queens, Staten Island, and in Hempstead Long Island.

- A complete employee physical exam
- Tuberculosis testing by PPD
- Flu Shots

CONTACT INFORMATION

BENEFIT	ADMINISTRATOR	WEBSITE | EMAIL | PHONE
Medical	Empire	empireblue.com 800-453-0113
Dental	Empire	empireblue.com 866-723-0515
Vision	Empire	empireblue.com 844-729-1566
Mass Transportation	Clarity	claritybenefitssolutions.com 732-428-8282
Employee Assistance	ComPsych	guidenceresources.com 800-272-7255
Annual Physical	Mobile Health	mobilehealth.net 212-695-5122
Allen Healthcare HR	Allen	718-657-2966
Benefit Eligibility	Boon Group	866-868-8310

OTHER AVAILABLE RESOURCES

NOTICE OF SPECIAL ENROLLMENT RIGHTS: PREMIUM ASSISTANCE UNDER MEDICAID & THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility.

ALABAMA | Medicaid | Website: http://myalhipp.com | Phone: 1-855-692-5447

ALASKA | Medicaid | The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/
Phone: 1-866-251-4861 | Email: Customer Service@MyAKHIPP.com |Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS | Medicaid | Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855) 692-7447)

COLORADO | Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)1-888-474-8275
Health First Colorado Website: https://www.healthfirstcolorado.com/ | Health First Colorado Member Contact Center
1-800-221-3943/ State Relay 711 | CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus | CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA | Medicaid | Website: http://flmedicaidtplrecovery.com/hipp/ | Phone: 1-877-357-3268

GEORGIA | Medicaid | Phone: (404) 656-4507 | Website: http://dch.georgia.gov/medicaid *Click on Health Insurance Premium Payment (HIPP)*

INDIANA | Healthy Indiana Plan for low-income adults 19-64 | Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479
All other Medicaid | Website: http://www.indianamedicaid.com | Phone: 1-800-403-0864

IOWA | Medicaid | Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | Phone: 1-888-346-9562

KANSAS | Medicaid | Website: http://www.kdheks.gov/hcf/ | Phone: 1-785-296-3512

KENTUCKY | Medicaid | Website: http://chfs.ky.gov/dms/default.htm | Phone: 1-800-635-2570

LOUISIANA | Medicaid | Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 | Phone: 1-888-695-2447

OTHER AVAILABLE RESOURCES

NOTICE OF SPECIAL ENROLLMENT RIGHTS CONT.

MAINE | Medicaid | Website: http://www.maine.gov/dhhs/ofi/public assistance/index.html | Phone: 1-800-442-6003 TTY: Maine relay 711

MASSACHUSETTS | Medicaid and CHIP | Website: http://www.mass.gov/eohhs/gov/departments/masshealth | Phone: 1-800-862-4840

MINNESOTA | Medicaid | Phone: 1-800-657-3739
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp

MISSOURI | Medicaid | Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: (573) 751-2005

MONTANA | Medicaid | Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP | Phone: 1-800-694-3084

NEBRASKA | Medicaid | Website: http://www.ACCESSNebraska.ne.gov | Phone: (855) 632-7633 | Lincoln: (402) 473-7000 | Omaha: (402) 595-1178

NEVADA | Medicaid | Website: https://dwss.nv.gov/ | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE | Medicaid | Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf | Phone: (603) 271-5218

NEW JERSEY | Medicaid and CHIP | Medicaid Phone: 609-631-2392 | Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-07108

NEW YORK | Medicaid | Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA | Medicaid | Website: https://dma.ncdhhs.gov/ | Phone: (919) 855-4100

NORTH DAKOTA | Medicaid | Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

OKLAHOMA | Medicaid and CHIP | Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742

OREGON | Medicaid | Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
http://www.oregonhealthcare.gov/index-es.html

PENNSYLVANIA | Medicaid | Phone: 1-800-692-7462
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm

RHODE ISLAND | Medicaid | Website: http://www.eohhs.ri.gov/ | Phone: (855) 697-4347

SOUTH CAROLINA | Medicaid | Website: https://www.scdhhs.gov | Phone: 1-888-549-0820

SOUTH DAKOTA | Medicaid | Website: http://dss.sd.gov | Phone: 1-888-828-0059

TEXAS | Medicaid | Website: http://gethipptexas.com/ | Phone: 1-800-440-0493

UTAH | Medicaid and CHIP | Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip | Phone: 1-877-543-7669

VERMONT | Medicaid | Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427

VIRGINIA | Medicaid and CHIP | Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924 | CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm | CHIP Phone: 1-855-242-8282

OTHER AVAILABLE RESOURCES

NOTICE OF SPECIAL ENROLLMENT RIGHTS CONT.

WASHINGTON | Medicaid | Phone: 1-800-562-3022 ext. 15473
Website: http://www.hca.wa.gov/free-or-lowcost-health-care/program-administration/premium-payment-program

WEST VIRGINIA | Medicaid | Website: http://mywvhipp.com/ | Toll-free phone: 1-855-699-8447

WISCONSIN | Medicaid and CHIP | Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING | Medicaid | Website: https://wyequalitycare.acs-inc.com/ | Phone: (307) 777-7531

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
1-866-444-EBSA (3272)
http://www.dol.gov/ebsa

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
1-877-267-2323, Menu Option 4, Ext. 61565
http://www.cms.hhs.gov/

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

WOMEN'S HEALTH ACT

The Women's Health and Cancer Rights Act of 1998 required that all health insurance plans that cover mastectomy also cover the following medical care:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas, and mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

OTHER AVAILABLE RESOURCES

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income. Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than your gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of hospital stay to less than 48 hours for a normal delivery or 96 hours for a Cesarean delivery or from requiring the provider to obtain pre authorization for a stay of 48 or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for Cesarean delivery.

MENTAL HEALTH PARITY ACT

According to the Mental Health Parity Act of 1996, the lifetime maximum and annual maximum dollar limits for mental health benefits under the medical plan are equal to the lifetime maximum and annual maximum dollar limits for medical and surgical benefits under this plan. However, mental health benefits may be limited to a maximum number of treatment days per year or series per lifetime.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The client in accordance with the HIPAA, protects your Protected Health Information (PHI). The client will only discuss your PHI with medical providers and third party administrators when necessary to administer the plan that provides you your medical, dental, and vision benefits or as mandated by law. A copy of the Notice of Privacy Practices is available upon request in the Human Resources Department.

This brochure summarizes the health care and income protection benefits that are available to the client and their eligible dependents. Official plan documents, policies, and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department.

Information provided in this brochure is not a guarantee of benefits.

TERMS TO KNOW

Annual Limit
Many health insurance plans place dollar limits upon the claims the insurer will pay over the course of a plan year. PPACA prohibits annual limits for essential benefits for plan years beginning after Sept. 23, 2010.

Balance Billing
When you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for unpaid amount.

COBRA Coverage
Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates. The law generally covers health plans maintained by private sector employers with 20 or more employees, employee organizations, or state or local governments. Many states have "mini-COBRA" laws that apply to the employees of employers with less than 20 employees.

Coinsurance
A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy.

Co-pay
The flat fee you pay out of pocket each time you visit a provider.

Cost Sharing
Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include deductibles, coinsurance and copayments. Balance billed charges from out-of-network physicians are not considered cost-sharing. PPACA prohibits total cost sharing exceed $5,950 for an individual and $11,900 for a family. These amounts will be adjusted annually to reflect the growth of premiums.

Deductible
The amount you pay during the year for medical services, before your insurance starts to pay.

Formulary
A list of generic and brand name prescribed medications covered by your health plan that treat the same conditions, but cost less.

Health Maintenance Organization (HMO)
A type of managed care organization (health plan) that provides health care coverage through a network of hospitals, doctors and other health care providers. Typically, the HMO only pays for care that is provided from an in-network provider. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.

Health Savings Account (HSA)
The Medicare bill signed by President Bush on Dec. 8, 2003 created HSAs. Individuals covered by a qualified high deductible health plan (HDHP) (and have no other first dollar coverage) are able to open an HSA on a tax preferred basis to save for future qualified medical and retiree health expenses. Additional information about HSAs can be found on the U.S. Treasury Web site: http://www.treas.gov/offices/publicaffairs/hsa/.

High Deductible Health Plan (HDHP)
A type of health insurance plan that, compared to traditional health insurance plans, requires greater out-of-pocket spending, although premiums may be lower. In 2010, an HSA-qualifying HDHP must have a deductible of at least $1,200 for single coverage and $2,400 for family coverage. The plan must also limit the total amount of out of-pocket cost-sharing for covered benefits each year to $5,950 for single coverage and $11,900 for families

HIPAA (Health Insurance Portability and Accountability Act of 1996)
The federal law enacted in 1996 which eased the "job lock" problem by making it easier for individuals to move from job to job without the risk of being unable to obtain health insurance or having to wait for coverage due to pre-existing medical conditions.

In-Network Provider
A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an HMO or PPO). The provider agrees to the managed care organization's rules and fee schedules in order to be part of the network and agrees not to balance bill patients for amounts beyond the agreed upon fee.

Mandated Benefit
A requirement in state or federal law that all health insurance policies provide coverage for a specific health care service.

Medicaid
A joint state and federal program that provides health care coverage to eligible categories of low-income individuals. Rules for eligible categories (such as children, pregnant women, people with disabilities, etc), and for income and asset requirements, vary by state. Coverage is generally available to all individuals who meet these state eligibility requirements. Medicaid often pays for longterm care (such as nursing home care). PPACA

TERMS TO KNOW

extends eligibility for Medicaid to all individuals earning up to $29,326 for a family of four.

Medicare
A federal government program that provides health care coverage for all eligible individuals age 65 or older or under age 65 with a disability, regardless of income or assets. Eligible individuals can receive coverage for hospital services (Medicare Part A), medical services (Medicare Part B), and prescription drugs (Medicare Part D). Together, Medicare Part A and B are known as Original Medicare. Benefits can also be provided through a Medicare Advantage plan (Medicare Part C).

Open Enrollment Period
A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as if one has had a birth, death or divorce in their family, individuals may be allowed to enroll in a plan outside of the open enrollment period.

Out-Of-Network Provider
A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization's network (such as an HMO or PPO). Depending on the managed care organization's rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider.

Out-Of-Pocket Limit
An annual limitation on all cost-sharing for which patients are responsible under a health insurance plan. This limit does not apply to premiums, balance-billed charges from out of network health care providers or services that are not covered by the plan. PPACA requires out-of-pocket limits of $6,350 per individual and $12,700 per family, beginning in 2014. These amounts will be adjusted annually to account for the growth of health insurance premiums.

Patient Protection and Affordable Care Act (PPACA)
Legislation (Public Law 111-148) signed by President Obama on March 23, 2010. Commonly referred to as the health reform law.

Pre-existing Condition Exclusion
The period of time that an individual receives no benefits under a health benefit plan for an illness or medical condition for which an individual received medical advice, diagnosis, care or treatment within a specified period of time prior to the date of enrollment in the health benefit plan. PPACA prohibits pre-existing condition exclusions for all plans beginning January 2014.

Point-of-Service Plan (POS) & Preferred Provider Organization (PPO)
A health plan allowing the customer to choose to receive services from a participating (in-network) or nonparticipating (out-of-network) health care professional. The customer may be required to select a primary care physician (PCP) and can usually save more by using a participating health care professional.

Premium
The periodic payment required to keep a policy in force.

Preventive Benefits
Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. PPACA requires insurers to provide coverage for preventive benefits without deductibles, co-payments or coinsurance.

Usual, Customary and Reasonable Charge (UCR)
The cost associated with a health care service that is consistent with the going rate for identical or similar services within a particular geographic area. Reimbursement for out-of-network providers is often set at a percentage of the usual, customary and reasonable charge, which may differ from what the provider actually charges for a service.

Waiting Period
A period of time that an individual must wait either after becoming employed or submitting an application for a health insurance plan before coverage becomes effective and claims may be paid. Premiums are not collected during this period.