R & R Reinforcing Inc.

Benefits Guidebook
2016

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Please note: This enrollment guide is a summary of some of the benefits provided to eligible employees. R & R Reinforcing Inc. reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason without prior notification. The plans described in this bulletin are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make explanations of the plans in this bulletin as accurate as possible. However, should there be any discrepancy between this bulletin and the provisions of the insurance contract or plan documents, the provisions of the insurance contract or plan documents will govern.

THE WRITTEN DESCRIPTIONS IN THE INSURANCE CONTRACTS OR PLAN DOCUMENTS WILL ALWAYS GOVERN.

Dear Employees,

This “Employee Benefits Guidebook” is provided to you as a quick reference guide to address all of your benefits questions. We encourage you to share this guidebook with your family members and dependents to help you gain a better overall understanding of the benefits available to you through R & R Reinforcing Inc.

Based on eligibility, you are only able to join or make changes to your benefit elections during either the annual Open Enrollment period or due to a qualifying life event, such as starting a new job, getting married, loss of other coverage or for the birth of a child. In the case of a qualifying life event, you will have 30 days from the date of the event to join the plan otherwise you may join the plan during the designated annual Open Enrollment period.

The Open Enrollment period generally occurs during the month of February, with benefit renewals becoming effective on the following March 1st.

Please carefully review the information contained in this Guidebook and should you have any questions or need further assistance please contact:

Patty Thomas
540.545.8315
randr.reinforcing@yahoo.com

Sincerely,

R & R Reinforcing Inc.

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact

Patty Thomas
R & R Reinforcing, Inc.
P.O. Box 4397
Winchester, VA 22604
(540) 545-8315
randr.reinforcing@yahoo.com

Medical

UnitedHealthcare
A UnitedHealth Group Company

Medical Coverage – UHC Choice Plus QLL High Plan

www.myuhc.com (800) 683.3120

Benefit	High Plan	
	In-Network Only	Out-of-Network
Calendar Year Deductible		
Individual	$500	$1,000
Family	$1,500	$3,000
Plan Year Out of Pocket Maximum		
Individual (including deductible)	$3,000	$4,000
Family (including deductible)	$6,000	$8,000
Coinsurance		
Coinsurance Percentage	90% (you pay 10%)	70% (you pay 30%)
Preventive Care		
Routine Adult Physicals	Covered in full	30% Coinsurance After Deductible
Infant & Pediatric Preventive Care	Covered in full	30% Coinsurance After Deductible
Physician Services		
Physician	$25 copay	30% Coinsurance After Deductible
Specialist	$50 copay	30% Coinsurance After Deductible
Chiropractor	$25 copay	30% Coinsurance After Deductible
Diagnostic Services		
X-Rays, Lab Services	Covered in full	30% Coinsurance After Deductible
Imaging (CT/PET Scans, MRIs)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Hospital Services		
Inpatient Hospital Services	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Outpatient Hospital Services	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Emergency Care		
Emergency Room (waived if admitted)	$150 copay	$150 copay
Ambulance	10% Coinsurance After Deductible	10% Coinsurance After Deductible
Urgent Care Center	$75 copay	30% Coinsurance After Deductible
Mental Health / Substance Abuse		
Inpatient	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Outpatient	$25 copay	30% Coinsurance After Deductible
Prescription Drug Coverage		
Rx Deductible (waived for Tier 1)	N / A	N / A
Retail - 30 Day Supply (Tier 1 / Tier 2 / Tier 3)	$10 / $30 / $50	$10 / $30 / $50
Mail Order - 100 Day Supply	$25 / $75 / $125	Not Covered

Per Pay Period Employee Contributions	
Employee Only	$49.44
Employee + Spouse	$158.19
Employee + Child(ren)	$120.62
Employee + Family	$249.15

- *This guidebook is for illustrative purposes only, and is not a legal document. Please refer to your carrier's summary of benefits.*

Medical

UnitedHealthcare
A UnitedHealth Group Company

Medical Coverage – UHC Choice Plus MYO Low Plan

www.myuhc.com (800) 683.3120

Benefit	Low Plan	
	In-Network Only	Out-of-Network
Calendar Year Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Plan Year Out of Pocket Maximum		
Individual (including deductible)	$5,000	$8,000
Family (including deductible)	$10,000	$16,000
Coinsurance		
Coinsurance Percentage	80% (you pay 20%)	60% (you pay 40%)
Preventive Care		
Routine Adult Physicals	Covered in full	40% Coinsurance After Deductible
Infant & Pediatric Preventive Care	Covered in full	40% Coinsurance After Deductible
Physician Services		
Physician	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Specialist	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Chiropractor	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Diagnostic Services		
X-Rays, Lab Services	Covered in full	40% Coinsurance After Deductible
Imaging (CT/PET Scans, MRIs)	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Hospital Services		
Inpatient Hospital Services	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Outpatient Hospital Services	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Emergency Care		
Emergency Room (waived if admitted)	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Ambulance	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Urgent Care Center	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Mental Health / Substance Abuse		
Inpatient	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Outpatient	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Prescription Drug Coverage		
Rx Deductible (waived for Tier 1)	N / A	N / A
Retail - 30 Day Supply (Tier 1 / Tier 2 / Tier 3)	$10 / $30 / $50 after the deductible	$10 / $30 / $50 after the deductible
Mail Order - 100 Day Supply	$25 / $75 / $125 after the deductible	Not Covered

Per Pay Period Employee Contributions	
Employee Only	$35.48
Employee + Spouse	$113.55
Employee + Child(ren)	$86.58
Employee + Family	$178.84

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Dental

UnitedHealthcare
A UnitedHealth Group Company

Dental Coverage – UHC Voluntary Dental PPO Plan

www.myuhcdental.com (800) 683.3120

Benefit	Dental PPO	
	In-Network	Out-of-Network
Deductible		
Individual	$50	$50
Family	$150	$150
Annual Benefit Maximum		
Annual Maximum	$1,200	$1,200
Diagnostic & Preventive		
Periodic Oral Exam Cleaning (prophylaxis) Adult/Child Fluoride Sealants Space Maintainers X-Rays	100%	90%
Basic Services		
Fillings (Amalgam/Composite) Emergency Exams	80%	60%
Major Services		
Inlays/Onlays/Crowns Simple Extractions Oral Surgery Full/Partial Dentures and Bridges Endodontics Periodontics	50%	50%
Orthodontia		
Orthodontics	N / A	
Per Pay Period Employee Contributions		
Employee Only	$5.53	
Employee + Spouse	$11.06	
Employee + Child(ren)	$11.70	
Employee + Family	$18.05	

- Certain procedures may require a pre-treatment review.
- Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage of Summary Plan Description for waiting period and a list of benefit limitations and exclusions.
- This benefit summary provides selected highlights of the employee benefits program at R & R Reinforcing Inc. It is not a legal document and shall not be consulted as a guarantee of benefits nor of continued employment at R & R Reinforcing Inc. R & R Reinforcing Inc. reserves the right to amend, suspend or terminate any benefit plan, in or in part, at any time. The authority to make such changes rests with the Plan Administrator.

Vision

UnitedHealthcare
A UnitedHealth Group Company

Vision Coverage – UHC Voluntary Vision Plan

www.myuhcvision.com (800) 683.3120

	Vision Benefit	
Routine Vision Examination		
Every 12 Months	$10	Up to $40
Standard Clear Plastic or Glass Lenses - Every 12 Months		
Single Vision Lenses	Covered in full after $25 copay Includes standard scratch-resistant coating	Up to $40
Bifocal Lenses		Up to $60
Trifocal Lenses		Up to $80
Lentricular Lenses		Up to $80
Frames - Every 24 Months		
Allowance and Frequency	$130 Retail Frame Allowance	Up to $45
Contact Lenses (Instead of Glasses) - Every 12 Months		
Necessary	Covered in full after $25 copay	Up to $210
Elective	Up to $105	Up to $105

Per Pay Period Employee Contributions	
Employee Only	$1.18
Employee + Spouse	$2.24
Employee + Child(ren)	$2.63
Employee + Family	$3.70

Notice of Special Enrollment Rights: Premium Assistance Under Medicaid and 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 July 31, 2014. Contact your State for more information on eligibility –

ALABAMA Medicaid 1-855-692-5447	MAINE Medicaid 1-800-977-6740	OREGON Medicaid 1-800-699-9075
ALASKA Medicaid 1-888-318-8890	MASSACHUSETTS Medicaid and CHIP 1-800-462-1120	PENNSYLVANIA 1-800-692-7462
ARIZONA CHIP 1-877-764-5437	MINNESOTA 1-800-657-3629	RHODE ISLAND Medicaid 401-462-5300
ARKANSAS CHIP 1-888-474-8275	MISSOURI 573-751-2005	SOUTH CAROLINA 1-888-549-0820
CALIFORNIA Medicaid 1-866-298-8443	MONTANA 1-800-694-3084	SOUTH DAKOTA 1-888-828-0059
COLORADO Medicaid 1-800-866-3513	NEBRASKA 1-855-632-7633	TEXAS Medicaid 1-800-440-0493
FLORIDA Medicaid 1-877-357-3268	NEVADA 1-800-992-0900	UTAH Medicaid and CHIP 1-866-435-7414
GEORGIA Medicaid 1-800-869-1150	NEW HAMPSHIRE 603-271-5218	VERMONT– Medicaid 1-800-250-8427
IDAHO Medicaid; CHIP 1-800-926-2588; 1-800-926-2588	NEW JERSEY Medicaid; CHIP 609-631-2392 ; 1-800-701-0710	VIRGINIA – Medicaid and CHIP 1-800-432-5924; 1-855-242-8282
INDIANA Medicaid 1-800-889-9949	NEW MEXICO 1-888-997-2583	WASHINGTON Medicaid 1-800-562-3022 ext. 15473
IOWA Medicaid 1-888-346-9562	NEW YORK Medicaid 1-800-541-2831	WEST VIRGINIA Medicaid 1-877-598-5820
KANSAS Medicaid 1-800-792-4884	NORTH CAROLINA Medicaid 919-855-4100	WISCONSIN Medicaid 1-800-362-3002
KENTUCKY Medicaid 1-800-635-2570	NORTH DAKOTA Medicaid 1-800-755-2604	WYOMING Medicaid 307-777-7531
LOUISIANA Medicaid 1-888-695-2447	OKLAHOMA 1-888-365-3742	

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
http://www.cms.hhs.gov/ ~ 1-866-444-EBSA (3272)

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 lymphedemas, and mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

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)

R & R Reinforcing Inc. in accordance with the HIPAA, protects your Protected Health Information (PHI). R & R Reinforcing Inc. 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 R & R Reinforcing Inc. 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.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Patty Thomas R & R Reinforcing, Inc. P.O. Box 4397 Winchester, VA 22604 (540) 545-8315.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
R & R Reinforcing, Inc. P.O. Box 4397	54-1575641
5. Employer address	**6. Employer phone number**
P.O. Box 4397	(540) 545-8315

7. City	8. State	9. ZIP code
Winchester	VA	22604

10. Who can we contact about employee health coverage at this job?	
Patty Thomas	
11. Phone number (if different from above)	**12. Email address**
	randr.reinforcing@yahoo.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☑ Some employees. Eligible employees are:

  Full Time employees

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  Your legal spouse/domestic partner.
  You or your spouse's/domestic partner's biological children, stepchildren, adopted child or foster child up to age 26.

  ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Glossary of Health Insurance Terms

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. When making decisions about health coverage, consumers should know the specific meanings of terms used to discuss health insurance. Below are definitions for some of the more commonly used terms and how PPACA impacts their use.

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. This is known as "balance billing."

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-Payment — A flat-dollar amount which a patient must pay when visiting a health care 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 co-payments. Balance-billed charges from out-of-network physicians are not considered cost-sharing. PPACA prohibits total cost-sharing exceed $6,550 for an individual and $13,100 for a family. These amounts will be adjusted annually to reflect the growth of premiums.

Deductible — A dollar amount that a patient must pay for health care services each year before the insurer will begin paying claims under a policy. PPACA limits annual deductibles are adjusted annually to reflect the growth of premiums.

Formulary — The list of drugs covered fully or in part by a health plan.

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/public-affairs/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 2016, an HSA-qualifying HDHP must have a deductible of at least $1,300 for single coverage and $2,600 for family coverage. The plan must also limit the total amount of out-of-pocket cost-sharing for covered benefits each year to $6,550 for single coverage and $13,100 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.

Glossary of Health Insurance Terms

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 long-term care (such as nursing home care). PPACA 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 $6,550 per individual and $13,100 per family, in 2016. 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 non-participating (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.

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