Affordable Care Act; Health Care Reform law
The Patient Protection and Affordable Care Act (sometimes referred to as the Affordable Care Act, PPACA or ACA) is a law that was passed in March 2010 to improve access to affordable health insurance for many Americans.

Affordable Coverage
For employer-provided health insurance to be considered affordable under the Health Care Reform law, the amount that comes out of an employee’s paycheck for employee-only health care coverage may not be more than 9.5% of the employee’s household income.

Annual Limit
A maximum amount of money your health insurance plan will pay for a particular service, or a maximum number of visits the plan will cover for a particular service in a given year. If you reach it, you must pay all health care costs for that particular service for the rest of the year.

Benefits-Eligible
For 2014, employees who work an average of at least 36 hours per week are considered full-time and are eligible to enroll in TeleTech® health insurance.

Comprehensive Coverage
For employer-provided health insurance to be considered comprehensive under Health Care Reform law, the health care plans offered must cover at least a minimum amount of predefined health care services.

Cost-Sharing Discounts
Reduced dollar amounts for health insurance plan features like annual deductibles and coinsurance/copays that are available to some people who purchase their health insurance through the public marketplace (see also Subsidy). To be eligible for these reduced dollar amounts, the person buying the coverage must qualify based on the amount of his or her total household income (see also Benefits-Eligible).

Employer Responsibility
Beginning on January 1, 2015, this is the Health Care Reform law requirement that each company with at least 50 full-time equivalent, benefits-eligible employees must offer those employees the ability to enroll in company-provided health insurance, covering at least a minimal amount of benefits that the law defines as being comprehensive (see also Essential Health Benefits) and offered to employees at a minimum price that the law defines as affordable.

Essential Health Benefits
These are a set of services that the Health Care Reform law requires certain health care plans to cover:

- 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 care, wellness services and chronic disease management (see also Preventive Care)
- Pediatric services, including oral and vision care.
All health insurance plans offered through public marketplaces in every state must cover these services. State Medicaid plans must cover them, too. The TeleTech health insurance offering for 2014 covers many of these services, although not required to do so under the Health Care Reform law.

In addition, health insurance companies may not put a lifetime or annual dollar limit on plans that include these services.

**Federal Poverty Level (FPL)**
The FPL is a measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits that are available as a result of the Health Care Reform law. The 2013 federal Poverty Guidelines can be located at [http://aspe.hhs.gov/poverty/13poverty.cfm](http://aspe.hhs.gov/poverty/13poverty.cfm).

**Full-Time Employment Status**
For 2014, employees who work an average of 36 or more hours per week will be considered benefits-eligible. (Because weekly hours fluctuate up and down for some employees, TeleTech will review your average weekly hours to determine your benefits eligibility.)

**Guaranteed Issue**
This part of the Health Care Reform law requires health insurance plans to enroll individuals regardless of health status, age, gender or other factors. Except in some states, guaranteed issue does not limit how much you can be charged for your plan premium or other plan costs if you enroll and use your coverage.

**Guaranteed Renewal**
A part of the Health Care Reform law that requires health care plans to renew your policy as long as you continue to pay premiums. Except in some states, guaranteed renewal doesn't limit how much you can be charged for your plan premium or other costs if you renew your coverage.

**Health Insurance Exchange/Marketplace; Affordable Insurance Marketplaces**
(See Public Marketplaces)

**High-Cost Health Care Plan Excise Tax**
Sometimes called the “Cadillac tax,” this part of the Health Care Reform law goes into effect in 2018 and imposes a tax on employers and insurance companies that provide high-cost health care plans. This tax encourages employers and insurance companies to offer plans that make premiums more affordable.

**Individual Health Insurance Policy**
This is health insurance not tied to a person’s job, such as health insurance purchased from an insurance company through the public marketplace or through another insurance company operating outside the marketplace. These policies are regulated under state law.

**Individual Mandate**
The rule under the Health Care Reform law that says you must have health insurance that meets basic minimum standards by January 1, 2014, or else pay an income tax penalty. (See also Minimum Essential Coverage.)

**Job-Based Coverage**
This is health insurance that is offered to an employee (and often his or her family) by the employer.

**Medicaid**
This is a state-run health insurance program for low- or middle-income adults, families and children, pregnant women, the elderly, people with disabilities, and in some states, others who qualify. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States then decide how to design their programs — so, Medicaid (or other names used to refer to the program) can vary by state. **The Health Care Reform law expands Medicaid eligibility in many states, which means some people are now eligible for Medicaid in 2014 who were not eligible before.** In addition to helping you navigate the public marketplace, your state’s marketplace representatives will be the best resources for helping you determine your Medicaid eligibility (see also Public Marketplaces).

**Medicare**
This is a federal system of health insurance for people 65 years of age and older, and for certain younger individuals with disabilities or end-stage renal disease (ESRD).
Minimum Essential Coverage
This is the type of coverage an individual needs to have in order to meet the Individual Mandate under the Health Care Reform law. You can get minimum essential coverage in a variety of ways, through job-based coverage (like the TeleTech health insurance offering for 2014, or coverage through the employer of your spouse/domestic partner or parents), health insurance you purchase on your own (through a public marketplace or an insurance company operating outside the marketplace), Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Out-of-Pocket Costs
These are your expenses for medical care that aren't paid up front or reimbursed by your health insurance company. They include deductibles and coinsurance/copays for covered services, plus all costs for services that aren't covered by your plan.

Out-of-Pocket Limit
The out-of-pocket (OOP) limit is the most you are required by your health insurance company to pay during a calendar year before your plan begins covering 100% of the allowed amount under your plan description. The OOP limit generally includes all deductible, coinsurance and copay amounts you’ve paid during a calendar year. This limit never includes your annual plan premium, charges from health care providers to pay the balance of a bill, or health care services and costs your plan doesn't cover.

Premium
This is the total annual amount you pay to be enrolled in your health insurance plan. Depending on the plan you enroll in, you will typically pay your annual premium in monthly, quarterly or once-per-year payments.

Preventive Care
Routine services like screenings, check-ups and patient counselling that help prevent illnesses, disease or other health problems. Under the Health Care Reform law, you and your family may be eligible for some preventive care at no out-of-pocket cost to you.

Public Marketplaces
A service set up in each state to allow individuals and small businesses to buy affordable and qualified health insurance plans directly from insurance companies. The public marketplaces will offer a choice of health plans that provide different levels of benefits and have different costs. Representatives will be available to help people navigate their state’s public marketplace, understand available insurance options through the marketplace and even determine individual Medicaid eligibility (see also Medicaid).

Qualified Health Care Plan
A plan that is certified by the public marketplace and provides essential health benefits, follows established limits on cost-sharing (like deductibles, copays and out-of-pocket limits) and meets other requirements of the Health Care Reform law (see also Essential Health Benefits).

Subsidy
This is a form of financial assistance provided by the federal government for individuals to apply toward purchasing health insurance through the public marketplace. Under the Health Care Reform law, those who qualify can receive this assistance in the form of a tax credit advance or cost-sharing discount when purchasing health insurance through the public marketplace in their state (see also Cost-Sharing Discounts). **Subsidies generally are not available if you are eligible to enroll in TeleTech health care coverage, even if you choose not to enroll in TeleTech coverage** (see also Benefits-Eligible). TeleTech has researched this issue and feels our company’s health insurance offering for 2014 offers employees a competitive, comprehensive and affordable option compared to plans they may find through the public marketplace, even when using subsidy funds.

Tax Penalty
This is the income tax amount you may owe for every month starting January 1, 2014, in which you do not have qualified health insurance that meets requirements of the Health Care Reform law. For any year in which you incur this tax penalty, you will need to pay it to the IRS when filing your income tax return for that year. For instance, if you went without coverage from January through March in 2014, you would be required by law to add up the monthly penalty for three months and then report it on your 2014 federal income tax return forms.
Wellness Programs
These are programs intended to improve and promote personal health, nutrition, fitness and other types of well-being, usually offered through employers but sometimes also offered by insurance companies to those who enroll in one of their covered health care plans. These programs offer benefits such as premium discounts, cash rewards, gym memberships and other incentives for participating in approved wellness activities. Some examples of wellness programs include programs to help you stop smoking, manage diabetes, lose weight or get types of preventive care.

Questions?
Visit these helpful websites:
  o www.healthcare.gov
  o www.kff.org