

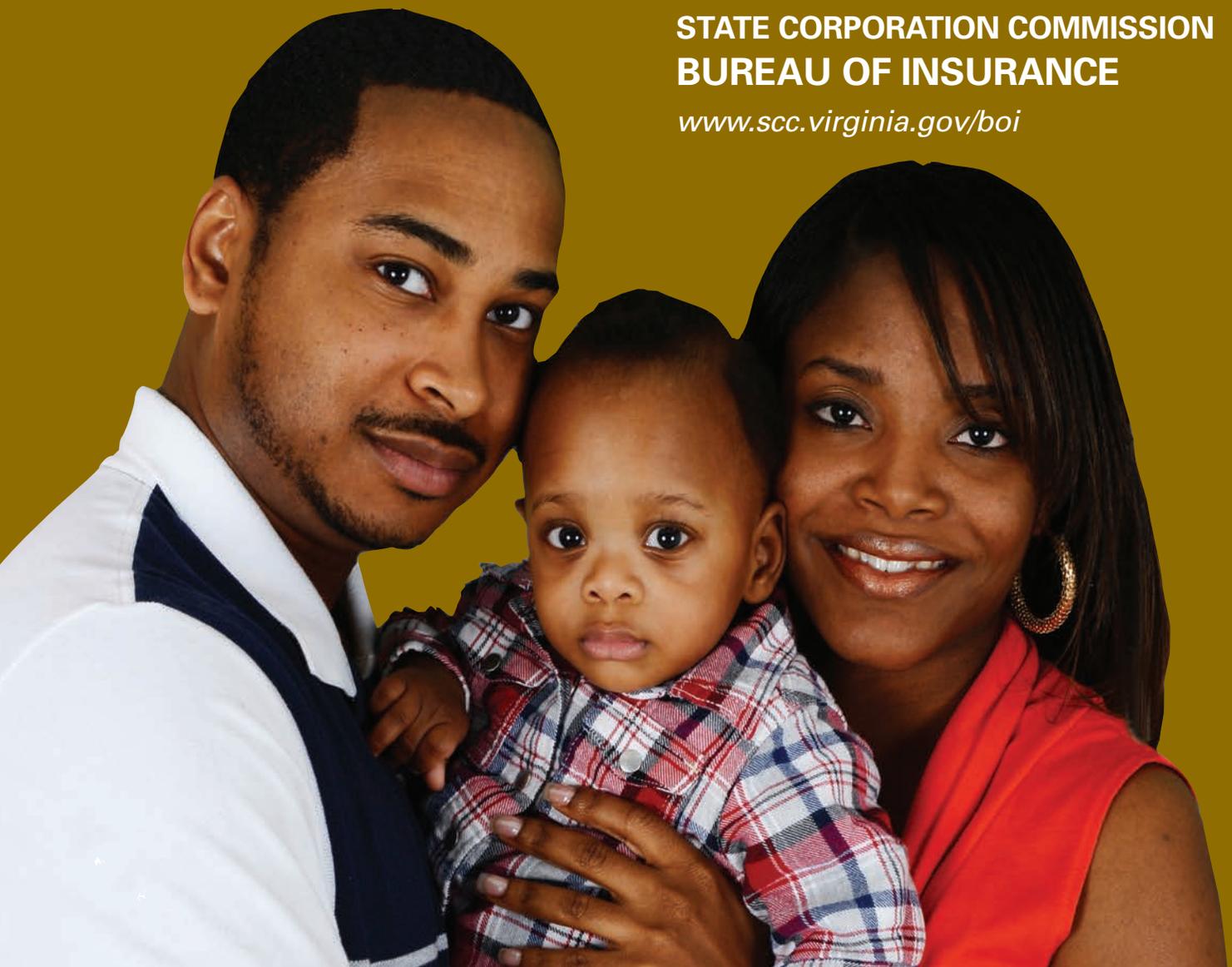


Virginia
HEALTH INSURANCE
Consumer's Guide



Prepared by
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

www.scc.virginia.gov/boi





Virginia HEALTH INSURANCE

Consumer's Guide

This Consumer's Guide should be used for educational purposes only. Nothing in this Guide is intended to be an opinion, legal or otherwise, of the State Corporation Commission, nor should it be construed as an endorsement of any product, service, person or organization mentioned in this Guide.



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ABOUT THIS GUIDE

Health insurance has undergone many changes in recent years, ranging from requirements that impact benefits, to the way many people purchase their health insurance coverage. Many of these changes resulted from the passage of the federal Patient Protection and Affordable Care Act (Affordable Care Act or ACA) along with conforming Virginia state insurance laws. The Bureau of Insurance (Bureau) developed this Guide to assist Virginia’s consumers in evaluating and understanding their health insurance coverage options in light of these many changes.

This Guide includes a brief overview of many of the significant recent benefit changes as well as an explanation of the federal Health Insurance Marketplace (Marketplace) and the Small Employer Health Options Marketplace (SHOP), both of which are sometimes referred to as the “Exchange.” It also includes a glossary of the **bolded** terms used in this Guide. This Guide also includes contact information and additional resources that are helpful in evaluating and understanding your health insurance options.

This Guide is comprised of the following major sections:

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The Bureau of Insurance is here to help you with any questions you may have about health insurance coverage. Please do not hesitate to call our Consumer Services Section (see Important Contact Information, Page iv) and ask questions.



An informed consumer is always in a better position to make a wise decision about his insurance needs. **Knowledge is your best policy.**



IMPORTANT CONTACT INFORMATION

(HOW TO REACH US)

STATE CORPORATION COMMISSION BUREAU of INSURANCE

Physical Deliveries/Visits:

Life & Health Division
1300 E. Main Street
Richmond, VA 23219

Mailing address:

Life & Health Division
P. O. Box 1157
Richmond, VA 23218
(Fax) (804) 371-9944

Web site

www.scc.virginia.gov/boi

Email Address

BureauofInsurance@scc.virginia.gov

LIFE & HEALTH DIVISION CONSUMER SERVICES SECTION

(Toll-Free) 1-877-310-6560
(In Richmond) (804) 371-9691

TDD USERS ONLY

Telecommunications Device for the Deaf
(804) 371-9206

ASSISTANCE for NON-ENGLISH SPEAKING CONSUMERS

(804) 371-9741
(804) 371-9691
(Toll-Free) 1-877-310-6560

OFFICE of the MANAGED CARE OMBUDSMAN

(Toll-Free) 1-877-310-6560
(In Richmond) (804) 371-9032
(Email) ombudsman@scc.virginia.gov

OFFICE of INDEPENDENT EXTERNAL REVIEW

(Toll-Free) 1-877-310-6560
(In Richmond) 371-9913
(Fax) (804) 371-9915
(Email) ExternalReview@scc.virginia.gov

INSURANCE OUTREACH

(Toll-Free) 1-877-310-6560
(In Richmond) (804) 371-9092
(Email) L&HOutreach@scc.virginia.gov

OTHER IMPORTANT CONTACT INFORMATION

(Entities Not Affiliated with the State Corporation Commission)

HEALTH INSURANCE MARKETPLACE

for Virginia
(Website) www.HealthCare.gov
(Toll-Free) 1-800-318-2596
(TTY) 1-855-889-4325

SMALL BUSINESS HEALTH OPTIONS MARKETPLACE (SHOP)

for Virginia
(Website) www.healthcare.gov/small-businesses
(Toll-Free) 1-800-706-7893
(TTY) 711

UNITED STATES DEPARTMENT OF LABOR

(Website) www.dol.gov/ebsa/healthreform
(Toll-Free) 1-866-444-3272

RESOURCE to FIND LOCAL MARKETPLACE ASSISTERS

(Website) <https://LocalHelp.HealthCare.gov>
(Toll-Free) 1-800-318-2596
(TTY) 1-855-889-4325

AFFORDABLE CARE ACT HOTLINE

U.S. Center for Consumer Information and Insurance Oversight
(Toll-Free) 1-888-393-2789

ADDITIONAL RESOURCES FOR SMALL EMPLOYERS:

IRS Affordable Care Act News Releases, Multimedia and Legal Guidance:
www.irs.gov/uac/Affordable-Care-Act-of-2010-News-Releases-Multimedia-and-Legal-Guidance

U.S. Department of Labor Patient Protection and Affordable Care Act Information:
www.dol.gov/ebsa/healthreform

U.S. Small Business Administration Health Care Reform Page
www.sba.gov/healthcare

In recent years, a number of significant changes were made in the requirements that apply to health insurance...

1.



1.



RECENT HEALTH INSURANCE LEGISLATION

In recent years, a number of significant changes were made in the requirements that apply to health insurance, most of which resulted from the passage of the **Affordable Care Act or ACA**, which became federal law on March 23, 2010. Several of the ACA's provisions relating to health insurance coverage became effective as health carriers issued new plans or policies or renewed existing plans or policies on or after September 23, 2010. Additional provisions of the ACA became effective on January 1, 2014. In Virginia, a number of state laws were revised or enacted to conform Virginia law to the health insurance coverage requirements in the ACA.

Generally, the provisions of the laws implementing these changes apply to all **health benefit plans** and policies, but there are some exceptions. For example, some requirements either do not apply or apply differently to plans issued in the **large group market**. There are also a number of requirements of the law that do not apply to grandfathered plans (see Grandfathered Plans, Page 13). You should contact your employer, your health insurer, and/or your insurance agent if you have questions about the type of plan you have and the requirements that may apply to it.



Generally, you can only purchase individual health insurance coverage during an annual Open Enrollment period.

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SHOPPING FOR HEALTH INSURANCE

Beginning in 2014, individuals and small employers and their employees now have two options with respect to their health insurance coverage purchases, and there are a number of tools, resources and qualified individuals available to assist people with their purchases, (see Consumer Assistance, Page 15):

1. Coverage may be purchased through a marketplace through which plan offerings and **premium** rates may be viewed and compared. For **individual health insurance coverage**, the federal marketplace that operates for Virginia is referred to as the Health Insurance Marketplace (see The Health Insurance Marketplace (Marketplace), Page 3). For plans offered in the **small group market**, the federal marketplace that operates for Virginia is referred to as the SHOP Marketplace (see The Small Business Health Options Program Marketplace (SHOP), Page 4).
2. Individuals, small employers, and employees of small employers can also purchase health insurance coverage outside of the Marketplace or SHOP, similar to the way it has been purchased in the past.

Health carriers that offer plans in the Marketplace or SHOP will charge the same premium when the same health benefit plan is sold inside and outside of the Marketplace or SHOP.

The Health Insurance Marketplace (Marketplace)

The Marketplace is the name of the federal health insurance marketplace through which individuals in Virginia may shop for health insurance. By accessing the Marketplace online, you can view the various plans and their associated premium rates offered by a number of private insurers. Through the Marketplace, lower-income individuals can receive help to lower **out-of-pocket** costs with **reduced cost-sharing (deductibles, coinsurance or copayments)**. They also may be eligible to receive premium tax credits for a plan purchased inside the Marketplace. Consumers may purchase plans inside or outside the Marketplace (see Open & Special Enrollment Periods, Page 6). However, premium tax credits and cost-sharing reductions are not available for plans purchased outside the Marketplace. To learn more, or to apply for coverage through the Marketplace, see the Contact Information section on Page v of this Guide.



The Small Business Health Options Program Marketplace (SHOP)

The ACA created the Small Business Health Options Program Marketplace (SHOP) where small employers who want to offer coverage to their employees can shop for plans. In Virginia, the federal exchange is called the SHOP. Certain small employers may be eligible for tax credits for plans purchased on the SHOP. Rules pertaining to small employers inside or outside the SHOP include the following:

- A small employer may enroll at any time and is generally not subject to open enrollment requirements.
- Notwithstanding the above, if a small employer does not meet employee minimum participation or employer minimum contribution requirements, it may only enroll during an annual one-month open enrollment period.
- An employee may have a choice of certain plans in a level of coverage selected by his employer rather than one plan.
- Coverage under a **group health benefit plan** must not impose a **waiting period** that exceeds 90 days.

Coverage Outside of the Marketplace and/or the SHOP

In Virginia, health insurance coverage remains available in the market outside of the Marketplace or the SHOP. Regardless of whether health insurance is made available inside or outside of the Marketplace or SHOP (or both), it must be offered to any individual or employer who is eligible for coverage in Virginia and applies for it. Health carriers will charge the same premium for policies sold inside or outside of the Marketplace or SHOP. However, the insurance may not be made available for purchase at all times of the year (see Open & Special Enrollment Periods, Page 6). Premium tax credits or cost-sharing reductions are only available inside the Marketplace or SHOP.

You still will be able to buy some plans outside the Marketplace or SHOP that do not cover the Essential Health Benefits (for example, long-term care, disability income, hospital indemnity, specified disease, accident only, etc.). It is important to note, however, that the purchase of these more limited plans will not satisfy the requirement under the ACA to have minimum essential coverage (referred to as the individual mandate). You should contact your insurance agent for help in evaluating your health insurance options outside of the Marketplace or SHOP.

Comparing Health Benefit Plans and Policies

When deciding which plan or policy to purchase, it is important to compare the cost as well as the benefits and any policy exclusions. Consider what is most

important to you in a health care plan, including premium and cost sharing costs; the inclusion within the plan's network of doctors, facilities and other healthcare providers; and specific coverages that are particularly important to you.

Here are some questions to consider when comparing plans:

- Will I be covered if I need medical care while traveling? Are out-of-state or **out-of-network** providers covered? Is there a different out-of-network deductible?
- What is the annual out-of-pocket cost of this plan?
- For a family policy, is there one deductible for an individual and another for the family? Does the family deductible have to be met before any benefits are payable?
- Are my drugs covered on this plan? What is the cost for different prescription drugs I may need? Is there a separate deductible for prescriptions?
- Is my doctor part of this plan's network of providers? **NOTE:** Each health carrier in Virginia is required by law to provide you, upon enrollment, and subsequently make available at least once a year, a directory of its network providers, including those providers that are currently not accepting new patients. If this information is provided in a form other than a printed document, you have the right to request and receive a printed document. It is always a good idea to check with your carrier, however, because providers can enter and leave networks, potentially causing frequent changes to the information in the provider directory.

In addition to varying by plan, rates for insurance premiums in the **individual market** and **small group market** may vary based on whether or not you are purchasing individual health insurance coverage or health insurance coverage for your family, your geographic rating area (generally the area within Virginia in which you live or work), your smoking status and your age.

For help on these and other questions in comparing plans and rates, review the Consumer Assistance section of this Guide.

Types of Plans

Most types of health insurance plans cover hospital care, doctor visits and prescriptions. How these benefits are delivered varies by type of plan:

- **Health Maintenance Organizations (HMOs):** Under an HMO, you may be required to choose a primary care physician (PCP) from the HMO's provider network. Your PCP is responsible for managing your health care. You may, for example, need to get a referral from your PCP before seeing a specialist. Except for emergency treatment, you generally are required to use a network provider in order to



receive covered benefits and services. Non-emergency treatment received outside the network is usually not covered.

- **Preferred Provider Organizations (PPOs):** Under a PPO, the insurance carrier enters into contracts with selected hospitals and doctors to furnish services at a discounted rate. As a member of a PPO, you choose whether to seek care from a doctor or hospital who is a preferred or participating provider of your PPO with less out-of-pocket expense to you, or from a non-participating provider when you pay a higher deductible, copayment, or applicable coinsurance.
- **Point-of-Service (POS):** A hybrid of the PPO and HMO models, a POS may require you to select a primary care physician, as with a HMO, but you may also go to an out-of-network provider and pay more out-of-pocket, as with a PPO. POS plans generally offer less coverage for health care services received from providers outside the network than for services received from providers within the network.

Note: When you receive services from a health care provider that does not participate in your health carrier's PPO or POS network, the health care provider is not obligated to accept the health carrier's payment as payment in full and may bill you for the unpaid amount. This is known as balance billing.

Open & Special Enrollment Periods

Open Enrollment: Generally, you can only purchase individual health insurance coverage during an annual Open Enrollment period. These Open Enrollment periods are established by the federal government and are well publicized. Please consult one of the resources on the Important Contact Information page (see Page iv) for additional information about open enrollment periods.

Special Enrollment: Even when Open Enrollment is closed, you can purchase a new individual health insurance policy if you do so within 60 days from experiencing a "triggering event." Examples of these events are:

- Losing a job due to a layoff, a reduction in hours, loss of student health coverage, quitting a job, etc.
- Gaining a dependent due to marriage, birth, adoption, or placement in foster care. Pregnancy is not a triggering event.
- Divorce
- Loss of dependent status (e.g. aging off your parents' plan)
- Moving to another state or outside of your health benefit plan's service area
- Exhaustion of COBRA coverage

- Losing eligibility for Medicaid or the Children's Health Insurance Program (CHIP), referred to in Virginia as the Family Access to Medical Insurance Security or FAMIS
- Income increase or decrease that changes your eligibility for subsidies if you are enrolled in a Marketplace plan
- Change in immigration status

Metal Levels (Levels of Coverage)

To help you compare costs, health benefit plans and policies in the individual and small group markets inside and outside the Marketplace and SHOP are divided into four tiers, or "metal levels." Generally, plans with lower cost-sharing will have higher premiums, while plans with higher cost-sharing will have lower premiums. Cost-sharing is the portion you will pay for covered services, at least until you meet your annual out-of-pocket limit. The Metal Levels are designed to cover between 60% and 90% of the expected medical services costs, ranging from the lowest level (lowest premium; highest level of out-of-pocket costs when you receive non-preventive services) to the highest level (highest premium; lowest level of out-of-pocket costs when you receive non-preventive services) as follows in the sequence of **Bronze**, **Silver**, **Gold** and **Platinum**. For more information on Preventive Services, see Page 10.

Catastrophic Plans: Health carriers may offer a catastrophic plan to individuals only both on and off the Marketplace. In order to be eligible to purchase this type of plan, you either must be under 30 years of age or eligible for a hardship exemption. While a catastrophic plan must include coverage for Essential Health Benefits, it has a high deductible that you must pay before the health carrier begins to pay for most benefits other than preventive care. Contact the Marketplace (see Important Contact Information, Page v) for more information about eligibility for and benefits of catastrophic plans.

Multi-State Plans

Multi-state Plans are offered on the Marketplace and SHOP. The name Multi-state Plan refers to a program created by the ACA and overseen by the U.S. Office of Personnel Management (OPM) in which OPM contracts with private health insurers to offer health benefit plans or policies on the Marketplace in multiple states. More information on the program can be found at www.opm.gov/healthcare-insurance/multi-state-plan-program. **NOTE:** Though Multi-state Plans are designed to be offered for sale in more than one state, consumers are cautioned that, as is the case with other Marketplace plans, these plans do not necessarily extend coverage across state borders to provide non-emergency coverage in multiple states.

...a number of major changes took place that affect most health benefit plans and policies...

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HEALTH INSURANCE COVERAGE INFORMATION

As a result of the ACA and conforming changes to Virginia law, a number of major changes took place that affect most health benefit plans and policies sold and renewed in Virginia. Some major changes are:

- Health carriers must cover Essential Health Benefits (see below).
- No lifetime dollar limits or annual dollar limits may be placed on Essential Health Benefits coverage. However, there is no such prohibition on limits for any other benefits.
- Health insurance coverage must be made available to any eligible person who applies for coverage (see Open & Special Enrollment Periods, Page 6).
- Children can stay on their parents' health benefit plan that provides dependent coverage until age 26.
- Health carriers can no longer deny or refuse to renew coverage because of a **pre-existing condition**.
- Health carriers cannot charge a higher premium due to a person's gender or health condition that existed before the effective date of the health benefit plan or policy (see Comparing Health Benefit Plans and Policies, Page 4).
- There are no out-of-pocket costs for **preventive services** (see Preventive Services, Page 10).
- Health carriers must cover routine medical costs if a person participates in a clinical trial for cancer or other life-threatening diseases.

Essential Health Benefits

Essential Health Benefits are those benefits that must be included in every individual and small group health benefit plan or policy in Virginia. Large groups or **self-insured groups** are not required to cover all Essential Health Benefits; however, when these benefits are covered, no annual dollar limits or lifetime dollar limits may be applied. Essential Health Benefits include at least the following ten categories:

- Ambulatory patient services (outpatient health services provided to members who are not confined to a health care institution)
- Emergency services



- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatments
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, including chronic disease management
- Pediatric services, including oral and vision care. Note: Plans may be available that do not cover pediatric oral services. A separate dental policy should be available for purchase.

Preventive Services

Coverage is required for preventive services without any cost-sharing provided that you use a health care provider who participates in your health carrier's network. Examples of preventive services include:

- Blood pressure, diabetes, and cholesterol screenings and tests
- Many cancer screenings, including mammograms and colonoscopies (including polyp removal)
- Counseling from your health care provider on such topics as quitting smoking, losing weight, eating healthy, treating depression, and reducing alcohol use
- Routine vaccinations against disease, such as measles, polio, or meningitis
- Flu and pneumonia shots
- Counseling, screening, and vaccines to ensure healthy pregnancies
- Regular well-baby and well-child visits from birth to age 21
- Women's preventive services, including well-women visits; contraceptive coverage; breastfeeding support, supplies, and counseling; screening and counseling for interpersonal and domestic violence; HPV testing; and counseling and screening for HIV.



For a complete listing of preventive services, contact your health carrier or consult the following website: www.healthcare.gov/what-are-my-preventive-care-benefits.

Note: Be aware that your health benefit plan or policy is only required to cover these preventive services without cost-sharing when provided by an in-network provider. You may be required to pay the cost of an office visit. Your health benefit plan or policy may allow you to receive these services from an out-of-network provider, but may require cost-sharing.

...grandfathered plans are allowed to offer the same coverage they did prior to the ACA...

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GRANDFATHERED PLANS

A grandfathered health benefit plan or policy is a plan or policy that was in place before March 23, 2010 when the ACA became law. You may have a grandfathered health benefit policy if you are covered by an individual health insurance policy that you had on that date. If you are covered by a job-based health benefit plan that your employer first established before March 23, 2010 the plan may be a grandfathered plan even if you enrolled in the plan after that date. A plan or policy can lose its grandfathered status if it makes significant changes that reduce benefits or increase costs to insureds. In order to determine if your plan is grandfathered, you should call your health carrier or your employer.

Generally, grandfathered plans are allowed to offer the same coverage they did prior to the ACA; however it is important to note that even grandfathered plans are subject to certain requirements of the ACA and Virginia law, including the following:

- Prohibiting lifetime dollar limits on essential health benefits
- Prohibiting your insurance coverage from being cancelled retroactively based on an unintentional immaterial mistake on an application
- Allowing children up to age 26 to stay on or be added to a parent's health benefit plan or policy as long as that plan or policy offers dependent coverage. (Prior to January 1, 2014, grandfathered group health benefit plans did not need to provide this benefit to dependents if those dependents had access to other employer-sponsored health coverage. As the plan renews on or after January 1, 2014, children up to age 26 can stay on their parents' employer health benefit plan even if they are eligible for coverage through an employer.)
- Ensuring that consumers will have access to information about proposed health insurance premium rates
- Must not impose waiting periods longer than 90 days for group health benefit plans
- Must issue a **Summary of Benefits and Coverage** as well as a Uniform Glossary to help you in comparing plans when shopping for coverage and at coverage renewal

...there are individuals trained to help provide information you may need to make decisions about your health insurance purchase...

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CONSUMER ASSISTANCE

Representatives from the Bureau's Consumer Services Section (see Important Contact Information see Page iv") are available to assist you with any questions you may have concerning your health insurance coverage. If your question involves a plan that is not subject to the Bureau's regulatory oversight, we will refer you to the appropriate entity that can assist you. In addition to the Bureau's staff, there are individuals trained to help provide information you may need to make decisions about your health insurance purchase, (see "Other Important Contact Information" page v):

- **Insurance agents:** Health insurance agents sell insurance coverage on behalf of one or more health carriers. Health insurance agents are licensed by the Bureau and receive ongoing continuing insurance education. They can help educate you about health insurance policies, help you apply for coverage, and advise you concerning the type of health insurance coverage that best suits you and your family. Agents can sell insurance plans outside the Marketplace or SHOP, as they always have. You may contact the Bureau for a list of licensed health insurance agents or agencies that sell health insurance in your area.
- Agents who sell policies through the Marketplace or the SHOP have received extra training from HHS and passed a test at the end of their training. You may wish to talk with more than one agent before making a decision on which plan to buy since agents may not be required to provide information on all options available from all health carriers.
- **Navigators:** Navigators are individuals trained by the federal government to help consumers understand the insurance policies available through the Marketplace as well as insurance affordability programs, including Medicaid and CHIP, (FAMIS in Virginia) available to eligible individuals. Navigators can discuss your health insurance policy options and help you apply for coverage. Navigators must complete federal training, and must be registered with the Bureau of Insurance.
- **Certified Application Counselors:** Certified Application Counselors (CACs) provide enrollment assistance to consumers inside the Marketplace and can also answer questions about different health insurance plans. CACs must receive and successfully complete comprehensive training. They, too, can help educate consumers about health insurance plans and answer questions about the application process. CACs generally can be found at community health centers, hospitals, Medicaid agencies or consumer non-profit organizations.



GLOSSARY OF TERMS

Important Note: The National Association of Insurance Commissioner (NAIC), an organization of insurance regulators from the 50 states, the District of Columbia and the five U.S. territories, has posted “Glossary of Health Insurance Terms” on its website at: www.naic.org/documents/index_health_reform_glossary.pdf. The information provided below uses some of the terms and definitions posted on the NAIC’s website. Please refer to the website above for the full glossary of health insurance terms and any updates to these terms and meanings.

Affordable Care Act or ACA – The name given to two pieces of legislation enacted in March 2010 – the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Together these pieces of legislation are referred to as the Affordable Care Act (ACA).

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

Copayment – A flat-dollar amount which a patient pays when visiting a health care provider.

Cost-sharing – Health care provider charges for which a patient is responsible under the terms of a health benefit plan or policy. Common forms of cost-sharing include deductibles, coinsurance, and copayment. Balance-billed charges from out-of-network providers are not considered cost-sharing.

Deductible – A dollar amount that a patient must pay for health care services each year before the health carrier will begin paying certain claims under a health benefit plan or policy.

Group health benefit plan – An employee welfare benefit plan that provides medical care for employees, including both current and former employees and their dependents directly or through insurance, reimbursement, or otherwise.

Health benefit plan – A benefit plan that provides medical care for a group of participants or their dependents directly or through insurance, reimbursement, or otherwise.



In-network provider – A health care provider, such as a hospital or doctor, which has contracted to be part of the network for a managed care organization (such as an HMO or a 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.

Individual health insurance coverage or individual health insurance policy – Health insurance offered to individuals other than in connection with an employment-based group health benefit plan.

Individual market – The market for health insurance coverage offered to individuals other than in connection with a group health benefit plan. The ACA makes numerous changes to the rules governing insurers in the individual market.

Large groups/large group market – The market for health insurance coverage offered to large businesses – those with more than 50 employees. In 2016, Virginia law changes this definition to those businesses with more than 100 employees.

Out-of-network – Care rendered by 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 out-of-network. The individual may also be balance billed for out-of-network care.

Out-of-pocket – There is an annual out-of-pocket maximum on all cost-sharing for which patients are responsible under a health benefit plan or policy. 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 health benefit plan or policy.

Pre-existing condition – Any physical or mental health condition, disability, or illness that existed for a person before that person applied for health care coverage.

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 that **existed** for a person before that person applied for coverage. The ACA prohibits pre-existing condition exclusions for health benefit plans and policies beginning January 1, 2014, except grandfathered individual health insurance policies.

Premium – The periodic (usually monthly) payment required to keep a policy in force.

Preventive services – Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. Virginia law requires health carriers to provide coverage for preventive benefits without deductibles, copayments, or coinsurance.

Self-insured groups/self-insured plans – Group health benefit plans may be self-insured or fully-insured. A plan is self-insured (or self-funded) when the employer assumes the financial risk for providing health care benefits to its employees. A plan is fully-insured when all benefits are guaranteed under a contract of insurance that transfers that risk to a health carrier.

Small group market – The market for health insurance coverage offered to small employer groups– those with at least 1 but no more than 50 employees. In 2016, Virginia law will broaden this term to those with at least 1 but no more than 100 employees.

Summary of Benefits and Coverage – A Summary of Benefits and Coverage (SBC) is a document that provides uniform information about your coverage in concise, plain language. It also includes a Uniform Glossary of terms used in medical care and health insurance. Health carriers offering coverage in the individual and small group markets must use this standard form. The SBC includes coverage examples of what your health benefit plan or insurance company will pay in two medical situations: diabetes care and childbirth. An example of the SBC and Uniform Glossary are available at www.Healthcare.gov.

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



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