# 600.5 Definitions and use of terms.

For purposes of this part, the following definitions apply:

Advance payments of the premium tax credit means payment of the tax credit authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.

Affordable Care Act is the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Basic Health Program (BHP) Blueprint is the operational plan that a State must submit to the Secretary of Health and Human Services (HHS) for certification to operate a BHP.

Certification means authority to operate the program which is required for program operations but it does not create an obligation on the part of the State to implement a BHP.

Code means the Internal Revenue Code of 1986.

Cost sharing means any expenditure required by or on behalf of an enrollee with respect to covered health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers and spending for non-covered services.

Enrollee means an eligible individual who is enrolled in a standard health plan contracted to operate as part of a BHP.

Essential health benefits means the benefits described under section 1302(b) of the Affordable Care Act, as determined in accordance with implementing regulations at 45 CFR 156.100 through 156.110 and 156.122 regarding prescription drugs.

Family and family size is as defined at 26 CFR 1.36B-1(d).

Federal fiscal year means the time period beginning October 1st and ending September 30th.

Federal poverty level or FPL means the most recently published Federal poverty level, updated periodically in the Federal Register by the secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2).

Household income is as defined in 26 CFR 1.36B-1(e)(1) and is determined in the same way as it is for purposes of eligibility for coverage through the Exchange.

Indian means any individual as defined in section 4 (d) of the Indian Self-Determination and Education Assistance Act (Pub. L 93-638).

Interim certification is an approval status for the initial design of a state's Basic Health Program. It does not confer any permission to begin enrollment or seek federal funding.

Lawfully present has the meaning given in 45 CFR 152.2.

Minimum essential coverage has the meaning set forth at 26 CFR 1.5000A-2, including coverage recognized by the Secretary as minimum essential coverage pursuant to 26 CFR 1.5000A-2(f). Under that authority, the Secretary recognizes coverage through a BHP standard health plan as minimum essential coverage.

Modified adjusted gross income is as defined in 26 CFR 1-36B-1(e)(2).

Network of health care providers means an entity capable of meeting the provision and administration of standard health plan coverage, including but not limited to, the provision of benefits, administration of premiums and applicable cost sharing and execution of innovative features, such as care coordination and care management, and other requirements as specified under the Basic Health Program. Such entities may include but are not limited to: Accountable Care Organizations, Independent Physician Associations, or a large health system.

Premium means any enrollment fee, premium, or other similar charge paid to the standard health plan offeror.

Preventive health services and items includes those services and items specified in 45 CFR 147.130(a).

Program year means a calendar year for which a standard health plan provides coverage for eligible BHP enrollees.

Qualified health plan or QHP means a health plan that has in effect a certification that it meets the standards described in subpart C of 45 CFR part 156 issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of 45 CFR part 156, except that such term must not include a qualified health plan which is a catastrophic plan described in 45 CFR 155.20.

Reference plan is a synonym for the EHB base benchmark plan and is defined at 45 CFR 156.100.

Regional compact means an agreement between two or more States to jointly procure and enter into contracts with standard health plan offeror(s) for the administration and provision of a standard health plan under the BHP to eligible individuals in such States.

Residency is determined in accordance with 45 CFR 155.305(a)(3).

Single streamlined application has the same meaning as application defined at 42 CFR 431.907(b)(1) of this chapter and 45 CFR 155.405(a) and (b).

Standard health plan means a health benefits package, or product, that is provided by the standard health plan offeror.

Standard health plan offeror means an entity that is eligible to enter into contracts with the State for the administration and provision of a standard health plan under the BHP.

State means each of the 50 states and the District of Columbia as defined by section 1304 of the Act.