Health Insurance

Health insurance is designed to help you pay your medical bills in the event you or a family member on your plan should become sick or injured. It can also help you pay for ongoing medical treatment and the management of chronic conditions.

Health insurance is a complicated subject – this is a very basic guide designed to help you make the most basic decisions and know what questions to ask. If you are covered by a group health insurance plan through an employer, speak with your HR representative or supervisor for information about your group insurance plan.

What does individual health insurance cover?

Health insurance covers most doctor bills, hospital bills, urgent care centers and clinics, and in many cases helps pay for prescription drugs. Often, health insurance also helps pay for physical therapy and other longer-term therapeutic and rehab services that arise as a result of a specific illness or injury.

Dental and vision coverage is frequently available as an add-on to a health insurance policy. These plans typically provide discounts on exams, eyeglasses, contacts, dental cleanings, and dental services.

What health insurance doesn't cover

Health insurance does not cover the cost of nursing home care, skilled nursing facilities, long-term custodial care, or assisted living facilities. To protect yourself against those types of costs, consider purchasing long-term care insurance.

Health insurance also does not cover income lost as a result of an illness or injury that prevents you from working. This is covered by disability income insurance policies.

Where can I get individual health insurance?

You can buy an individual or family health insurance policy from a health insurance agent or broker licensed in your state. You can do this in person, over the phone, or via an agent's or broker's website.

You also may buy health insurance via your state's Affordable Care Act (ACA) online health insurance exchange in your state. This option may be better for low-and-moderate income households, because you may be eligible for a federal subsidy to help pay your health insurance premium.

To learn more about your state's ACA exchange:

Visit: Healthcare.gov

www.healthcare.gov.

Note: while you can enroll in an employer group plan as soon as you are eligible after hire, the individual market typically requires you to enroll during the annual open enrollment period, unless a special circumstance applies.

Medicare

Medicare is a federal health insurance program for people aged 65 and older.

There are four parts to Medicare:

- Part A covers hospital costs;
- Part B covers physician's fees, lab fees, and durable medical equipment;
- Part C, or Medicare Advantage, is an optional program that provides expanded care options and coverage for medical services not covered under Parts A and B;
- Part D covers prescription drugs. Some Part C plans may also provide prescription drug coverage.

Medicare doesn't provide "free" health care to beneficiaries. There are substantial deductibles and co-pays in the Medicare program. To help manage risk, many seniors also purchase Medicare supplemental insurance, also called "Medigap" insurance. This coverage can save on deductibles and co-pays in the case of a medical event. These are private plans that are standardized among all insurance carriers. However, underwriting and pricing can vary, so shop around.

You don't need Medicare Advantage and Medicare Supplement insurance at the same time.

Medicaid

Medicaid is a joint state and federal program designed to help pay for basic medical care for the indigent. To qualify, you must meet low-income requirements and asset requirements that vary by state.

What about pre-existing conditions?

Under the terms of the Affordable Care Act (ACA), health insurance companies cannot discriminate against you on the basis of your health history or pre-existing medical conditions – provided you enroll during the annual open enrollment, or during a special enrollment period.

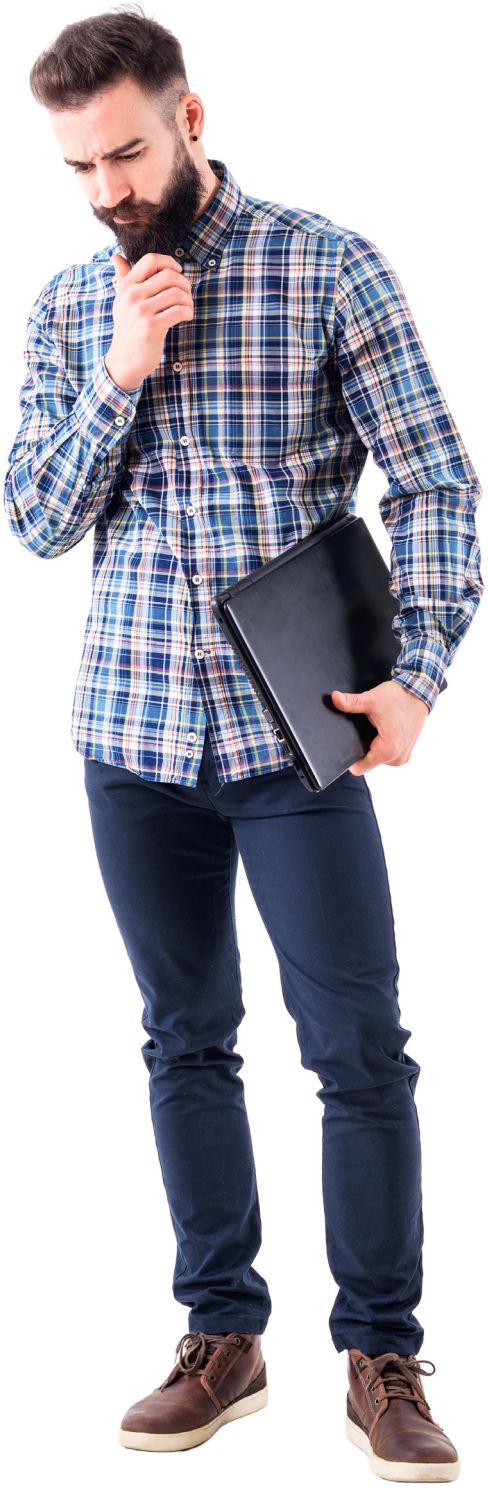
The general open enrollment period for ACA-compliant plans is usually November 1 through December 15 of one year, for plans starting on January 1 of the following year.

Generally, you won't be able to purchase a plan outside of either the general open enrollment period or a special enrollment period.

You may qualify for a special enrollment period under the following circumstances:

- You recently lost your existing health insurance coverage
- You moved to another state
- You got divorced or widowed
- You had a baby or adopted a child
- You got married
- You became a dependent
- You gained a dependent
- You had a change in income
- You were released from incarceration
- Someone on your marketplace plan died and you are no longer eligible for the plan as a result.

Outside of these enrollment periods, it will be difficult to get coverage in the individual market.



Key terms:

Deductible. Your deductible is the amount you must pay out-of-pocket in any given year before your insurance policy begins to pay benefits. Lower deductibles mean less risk for you, but you will have to pay higher premiums, all else being equal.

Catastrophic plans. These are plans that have very high deductibles and are designed to pay benefits only in worst-case scenarios. The deductible for all catastrophic plans is limited at a certain amount defined each year. Premiums are normally very low, but benefits are limited. To qualify, you must be under age 30, or qualify for a hardship exemption or an affordability exemption. More information here.

Children's Health Insurance Program (CHIP). If you have children and meet certain income requirements, you may be able to get health insurance for your children via your state's CHIP program.

Co-insurance. This is the percentage of your medical costs you will still have to pay after you meet your deductible. If you buy your health plan through your state's ACA insurance exchange, you can choose from among four tiers or co-pay options.

Bronze	You pay 40 percent of medical costs after your deductible.
Silver	You pay 30 percent of medical costs after your deductible.
Gold	You pay 20 percent of medical costs after your deductible.
Platinum	You pay 10 percent of medical costs after your deductible.

The more co-insurance you take on, the lower your premiums are likely to be.

Note: The Affordable Care Act (ACA) provides subsidies to qualifying individuals and families to make health coverage more affordable. For example, the premium tax credit lowers premium costs for people who purchase "Silver" plans through the federal or their state Marketplaces. In 2022, the tax credits were extended through 2025 by passage of the Inflation Reduction Act.

Co-pay. This is a flat fee you must pay for each medical service rendered, for example per doctor visit or per prescription filled, in addition to your co-insurance. Co-pays are typically $10 to $25 in most cases, and apply after you've paid your deductible for the year.

Cost sharing. This is the amount you must pay out-of-pocket and normally includes co-insurance, co-pays, and deductibles but not premiums (except for Medicaid and CHIP). The higher your

overall cost sharing, the lower your premiums, all else being equal.

Managed care plans. A managed care plan is a type of health plan that relies on putting together relatively narrower networks of care providers and physicians in order to decrease costs and keep premiums low. Physicians and care providers selected for the network agree to provide discounted prices to those in the plan, in exchange for a steady flow of patients. The narrower the network, the more bargaining power the network has, because the flow of patients in the plan will be more concentrated.

Managed care plans offer less choice compared to other plans. But they are generally successful at keeping overall premiums low.

Network. The network represents those health care providers who accept your insurance plan. Some plans, including HMOs and PPOs, have narrow networks from which you may choose, while other plans allow you to choose your own doctor, clinic, or hospital and will still pay benefits. Some plans require you to pay more out-of-pocket for non-emergency care you receive from out-of-network providers.

If you want to receive care from a specific doctor or hospital, you should check your plan's list of network providers before buying health insurance.

Primary care physician. In managed care plans, including HMOs, PPOs, and POS plans, your primary care physician (PCP) acts as your primary point of contact with the health care system, and as a gatekeeper who can provide you referrals to specialists (although PPOs allow you to go to specialists without a referral).

Premiums. Premiums are what you must pay each month in order to remain enrolled in the plan. People in the individual market and in Medicare must pay the entire premium. If you are in an employer group medical plan, your employer will pay part or all of the premium, and deduct your share of the premium (if any) from your paycheck. Any premiums they deduct will be itemized on your pay stubs and on your W-2 form at the beginning of the year.

Vision insurance. A vision insurance plan may help you afford basic eye care, including periodic eye exams and new glasses or contacts as needed.

Some, but not all, vision plans also offer discounts on elective vision correction surgery, such as PRK or LASIK. Preventive eye care is important and not just because you may need glasses every year or two: regular eye exams may also help you detect the onset of diabetes, or detect whether your diabetes is getting worse. Vision insurance can be purchased in conjunction with major medical insurance, or by itself.

Types of Health Insurance Plans

Here are the most common types of health insurance plans:

Health maintenance organizations (HMOs). These plans contract with a network of care providers. Premiums are relatively affordable, but you must receive care from within the network in order to get your plan to pay benefits other than for emergency care. Also, HMOs typically require you to get a referral from a primary care physician to see a specialist. These plans typically have low premiums and require relatively little paperwork, but offer patients the least flexibility or freedom to choose their own care providers.

Exclusive Provider Organizations (EPOs). These are managed care organizations that pay no benefits for non-emergency care from out-of-network providers. If you receive non-emergency care from a provider outside the network, you will pay all costs out-of-pocket. However, you usually don't need a referral from a primary care doctor to see a specialist. Paperwork is minimal.

Preferred provider organizations (PPOs). These plans also use a narrow network and offer relatively low premiums. These plans offer you more flexibility if you want to see a provider who is not in the plan's network, although they may pay a reduced amount and you will have to spend more out-of-pocket for out-of-network care.

Furthermore, with a PPO, you don't need a primary care doctor's referral to see a specialist. If you go out of network, you can expect to do more paperwork to get a claim paid, and the carrier may pay a reduced amount for out-of-network care. You also will have to pay out-of-pocket to see a provider outside the network, and then apply to get reimbursed.

Point of service plans (POSs). A point of service plan combines some aspects of HMOs and PPOs. You choose a primary care physician from within the network, but your PCP can refer you to care providers both within and outside the network. However, the insurer will generally cover less of the cost if you go outside the network. You can also expect more paperwork if you go out-of-network, and most likely you'll have to pay the out-of-network bills up front and then submit them to your POS insurance plan administrators for reimbursement.

High-deductible health plans (HDHPs). These are individual and family comprehensive medical insurance plans with high minimum deductibles. These plans also cap out-of-pocket expenses. The out-of-pocket cap applies to co-insurance, deductibles and co-pays, but not to premiums.

You must own an HDHP in order to be eligible to contribute to a health savings account (HSA), described below.

Health savings account (HSA). These are special tax-advantaged accounts that allow people with HDHPs to contribute pre-tax dollars to help them meet deductibles and co-insurance expenses. In order to contribute, you must own a qualified high-deductible health plan, and you cannot be eligible for coverage in any group health insurance plan.

Health savings account contributions are tax-deferred, and withdrawals to pay qualified medical expenses are tax-free. Withdrawals prior to a specified age are taxable as income and also carry a penalty, except in the event of your death or total and permanent disability.

You can accumulate money tax-deferred in an HSA for as long as you like, until you reach age 65. At that time, you can withdraw funds from your HSA for any reason, penalty-free. However, you'll still have to pay income taxes on those funds.