



Health Care Reform Law & You

How to get the most out of your health plan



Independence
Administrators



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Introduction

President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law on March 23, 2010, and the Health Care Reconciliation Act (HCRA) into law on March 30, 2010. Today it is known as the Affordable Care Act or the ACA. The main goals of the ACA are to expand coverage, require all to participate, make health care more affordable, improve the quality of care, and increase choice and competition.

Independence Administrators has created this guide, *Health Care Reform Law & You*, to help you understand how the health care reform law may affect you and your family. The majority of changes under the ACA are scheduled to take effect in January 2014.

As a participating member in your group health plan, you are covered and will continue to be covered when you re-enroll as the new health care law takes effect. If you have questions about your benefits plan, please contact your employer's benefits administrator.

The guide will also provide information for your family and friends who may not participate in a group health plan.

This guide includes:

- information on how **health benefits** work;
- the benefits of a group health plan;
- information for friends and family without a group health plan;
- a glossary on pages 12-14 that explains common health care terms.

This guide is helpful for people who:

- **want to understand their current health plan better;**
 - **want to know more about health care reform;**
 - **may not have a group health plan.**
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This guide has been prepared by Independence Administrators as a general reference source for your use. The guide is not intended to provide legal and/or tax advice.

The ABCs of Health Insurance

How Health Insurance Works

We don't plan to get sick or hurt but these events happen to people every day. Illnesses and injuries can be devastating to your health. They also can use up your savings and may lead to bankruptcy for some people.

Many people don't know how much medical services cost. The average cost of staying in the hospital for three days is \$30,000. The average cost of treating a broken leg is about \$5,500. The costs of more serious health problems can be crippling. Below are some examples of how much medical care can cost:

Health event	Care required	Cost without health benefits
3-year-old Sarah has an ear infection	Visit to doctor and cost of medication	\$114
10-year-old Joe breaks his arm	ER visit, x-rays, set cast, follow-up to remove cast, physical therapy	\$1,100
30-year-old Latisha is having a baby	Prenatal care, vitamins, ultrasound, delivery, hospital stay	\$7,720
50-year-old Bob has a heart attack	Ambulance, ER visit, surgery, hospital stay, cardiac therapy	\$71,055

Source: FAIR Health.

Benefits of a Group Health Plan

A group health plan is generally offered to you by your employer and provides you with access to health care. A group health plan helps you protect your health and wellness. It also limits your risk of paying for very expensive health care services. Through your participation in your group health plan, you have access to a network of doctors and hospitals. Your group health plan also pays for covered services you

receive from your health care provider. As a participating plan member, you are provided with services, support, and resources to help you manage your health and wellness.

Types of Group Health Plans

The most common types of group health plans are Preferred Provider Organizations (PPO), Health Maintenance Organization (HMO), Point of Service (POS), and Closed Panel PPO plans. These types of group health plans have several key differences.

PPO

In a PPO, you don't have to choose a primary care physician (PCP) and the doctors you see can be in or out of the group health plan's network. You can visit doctors, hospitals, and other health care providers of your choice, like a heart doctor, but you will pay more if your doctor does not participate in your group health plan's network.

HMO

In an HMO, you choose a family doctor, called a primary care physician (PCP), who provides the services you need. Your PCP refers you to other doctors or health care providers within the HMO network when you need specialized care. Typically, only emergency services are covered if you go outside of the plan's network. HMOs usually have the lowest premiums.

POS

POS plans combine features of HMOs and PPOs. You choose a PCP, but you have the flexibility to see doctors, hospitals, or other health care providers both preferred and non-preferred. You will pay less when you see preferred doctors, hospitals, and other health care providers, and more when you see non-preferred providers.

Closed Panel Preferred Provider Organization (PPO)

A Closed Panel PPO Plan allows you to maximize your health care benefits by using network providers. Closed Panel PPO Providers are health care providers that may be associated with a hospital system and are part of a network which includes hospitals, primary care physicians, and specialists, and a wide range of ancillary providers.

Paying for Care

With a group health plan, you still may pay each time you receive care from a doctor or hospital, have a prescription filled, or seek some type of medical care. These payments are frequently referred to as cost-sharing. How much you pay may vary depending on your group health plan and on whether you use a preferred provider or a non-preferred provider. The cost-sharing fees you may pay include:

Cost-sharing fee	How it works
Deductible	The amount you pay each year before your group health plan starts paying for covered services. For example, if your plan has a \$1,000 deductible, you will need to pay the first \$1,000 of the costs for the health care services you receive. Once you have paid this amount, your insurance will begin to pay a portion or all of your health care costs, depending on the group health plan.
Copayment	The flat fee you pay when you see a doctor or receive other services. For example, \$20 to see a doctor or \$100 to go to the emergency room.
Coinsurance	The percentage you pay for some covered services. If your coinsurance is 20 percent, your group health plan will pay 80 percent of the cost of covered services; you will pay the remaining 20 percent.

Group Health Plan Coverage

How will the health care reform law (the Affordable Care Act or ACA) affect you?

Having a group health plan is one of the most important things you can do for your health. Your group health plan pays for covered health care services to help you stay healthy and also covers many of the services you need when you're sick or injured.

As a member of your group health plan, you have access to a range of services to help protect you and your family. This guide will help you navigate some of the complexities of the health care reform law.

Recent ACA Benefit Changes to Your Group Health Plan

The ACA has implemented some key provisions that may impact your current health plan including:

- allowing coverage of dependent adult children until age 26;
- no pre-existing condition exclusions for individuals under 19;
- either providing a restricted annual dollar limit or removing the annual dollar limit on essential health benefits if essential health benefits are in your group health plan.

Depending on the type of group health plan you have, additional provisions include:

- preventive care with no cost-sharing
- women's preventive care with no cost-sharing

Coming in 2014: Benefit Changes to Your Group Health Plan

As a result of the ACA, some changes to your benefits in 2014 may include:

- coverage of dependents to age 26 if your group health plan covers dependents;
- no pre-existing condition exclusions for anyone;
- a waiting period of no longer than 90 days for new hires;
- removal of annual dollar limits for essential health benefits if essential health benefits are in your group health plan.

The Individual Federal Mandate

In 2014, if you do not have health coverage, you may be subject to a tax penalty.

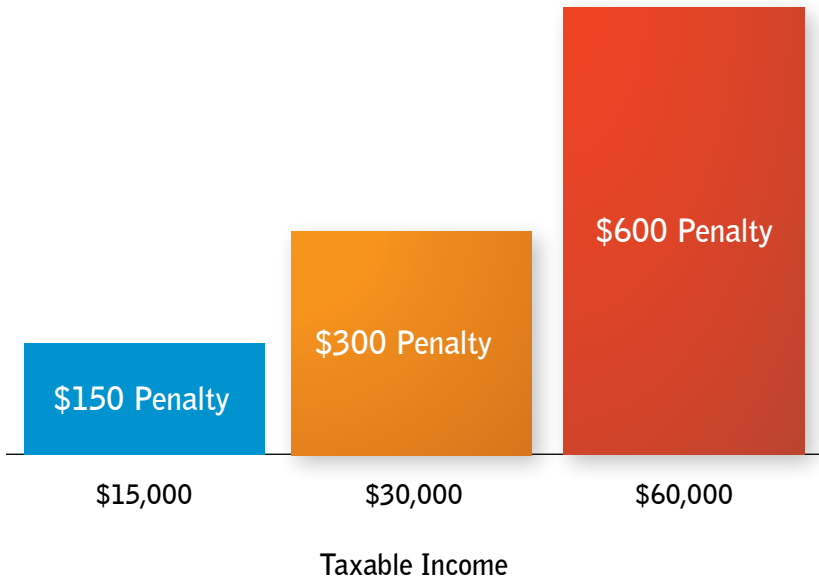
No Penalties through Group Health Plans

As a participating member of your group health plan, you are generally not subject to the penalties outlined below.

Most people will pay a penalty if they do not have a health plan. The penalty increases over the next few years, and the individual who does not have a health plan will be charged the greater of these amounts:

- 2014 penalty: \$95 or one percent of your taxable income
- 2015 penalty: \$325 or two percent of your taxable income
- 2016 penalty: \$695 or two and one-half percent of your taxable income

2014 Sample Penalty for Individuals Without a Health Plan





Penalties are applied per person. Individuals may be able to avoid the penalty if they are facing serious financial problems, have certain religious beliefs, or meet other requirements. For more information, visit www.healthcare.gov.

Questions on Your Health Benefits?

If you have questions about your group health plan, please contact your employer's benefits administrator.

Help Your Family and Friends Make Informed Decisions

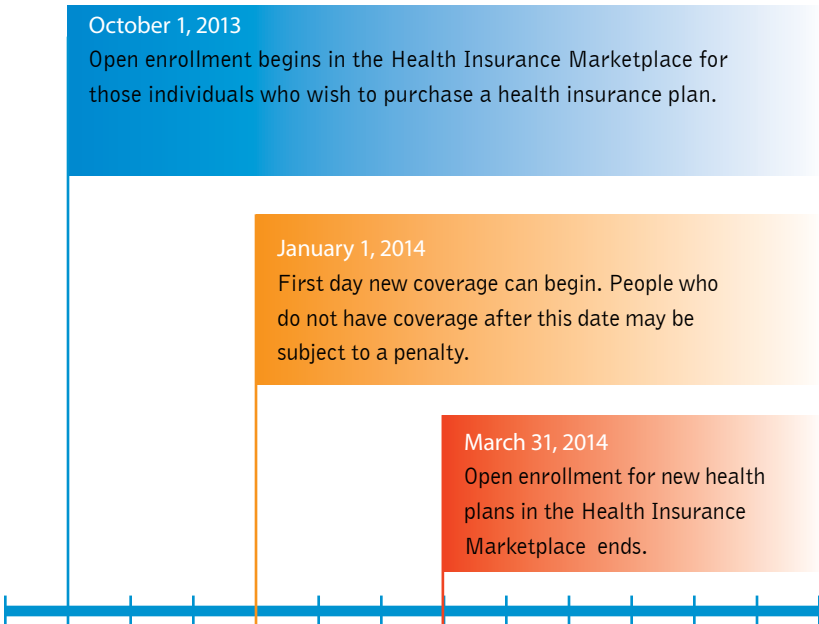
The health care reform law means more than having a health plan and the services it provides. It has features that protect your family and friends. The law provides the following protections:

- An individual cannot be denied health insurance coverage.
- An individual cannot be charged more for health insurance if they are sick.

Health Insurance Marketplace

The Health Insurance Marketplace is a new online website where your family and friends can compare and buy health insurance plans that can help make health plans more affordable.

Health Insurance Marketplace Timeline



Getting Reliable Help

There are free, easy, and confidential online tools available to help individuals make better choices about their health care.

- Visit the Health Insurance Marketplace through healthcare.gov;
- Call the Health Insurance Marketplace's toll-free number (available in October 2013)

Preparing for the Health Care Reform Law

Here are some things your family and friends who may not have coverage through a group health plan should consider when preparing for open enrollment:

- Make sure you know how health insurance plans work and what the most frequently-used terms mean (see the Glossary on pages 12-14).
- Consider a health insurance plan that meets your current medical needs and protects you if you have a serious injury or illness in the future.
- Learn about the different health plans that will be available and evaluate the companies offering them.
- Learn more about the networks of doctors and hospitals for the health insurance plans you're considering.
- Ask about each health insurance plan's list of approved prescription drugs it covers. This list is called a formulary.
- Try some online tools through healthcare.gov for an idea of how they can help you make your health care choices.

Glossary of Common Health Care Terms

Definitions of some of the health care terms in this guide:

- **Annual enrollment period**
The specific time each year that you can buy a health insurance plan, renew the plan you already have, or switch to another health plan.
- **Closed Panel Preferred Provider Organization (PPO)**
A Closed Panel PPO Plan allows you to maximize your health care benefits by using network providers. Closed Panel PPO Providers are health care providers that may be associated with a hospital system and are part of a network which includes hospitals, primary care physicians, and specialists, and a wide range of ancillary providers.
- **Coinsurance**
Your share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe.
- **Copayment (Copay)**
A fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
- **Cost-sharing**
The share of costs covered by your group health plan that you pay out of your own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums/ contributions, balance billing amounts for non-network providers, or the cost of non-covered services.
- **Deductible**
The amount you pay for health care services your plan covers before your health plan begins to pay. The deductible may not apply to all services.
- **Essential Health Benefits**
A list of core benefits that some health plans must provide under the health care reform law. Basic services include doctor visits and hospital stays. Benefits may also include preventive care, maternity care, and mental health services.



- **Formulary**
A list of approved drugs covered by a health insurance plan. There will usually be lower-cost and higher-cost drugs for a specific condition you may have. Your lowest costs are typically for generic drugs.
- **Health care reform**
The Patient Protection and Affordable Care Act. President Obama signed this bill into law in 2010. Key parts of the law go into effect in 2014.
- **Health Insurance Marketplace**
A new online website where you can compare and buy health insurance plans. Some states have their own Marketplace. Other states let the federal government operate their Marketplace.
- **Health Maintenance Organization (HMO)**
A type of health plan that requires you to select a family doctor, often called a primary care physician or PCP. You need a referral from your PCP to see an HMO network specialist, such as a cardiologist (heart doctor). Typically, only emergency services are covered if you go outside the health plan network.
- **Health plan**
A product that offers a specific set of health benefits for a certain cost.
- **Non-Preferred Provider**
The facilities, providers, and suppliers who do not have a contract with your health insurance plan. Members typically pay more for services from non-preferred providers.
- **Point-of-service plan (POS)**
A plan that requires you to choose a PCP to oversee your care. You also have the option of paying more to see providers outside the network.
- **Preferred Provider**
The facilities, providers, and suppliers who have contracted to provide covered services under your health plan.
- **Preferred Provider Organization (PPO)**
A type of health plan that allows members to see providers in and out of the network. You pay lower costs when you see network providers, but you can go outside the network and pay more for your services.



- **Premium**
The amount that must be paid for your health insurance plan.
- **Preventive services**
Services that help you stay healthy. They may also detect some diseases in the early stages. Flu shots, mammograms, and cholesterol tests are examples of preventive services.
- **Primary care physician (PCP)**
The doctor you see for most of your health care needs. PPOs do not require that you choose a primary care physician.
- **Provider**
A physician, health care professional, or health care facility licensed, certified, or accredited as required by state law.



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