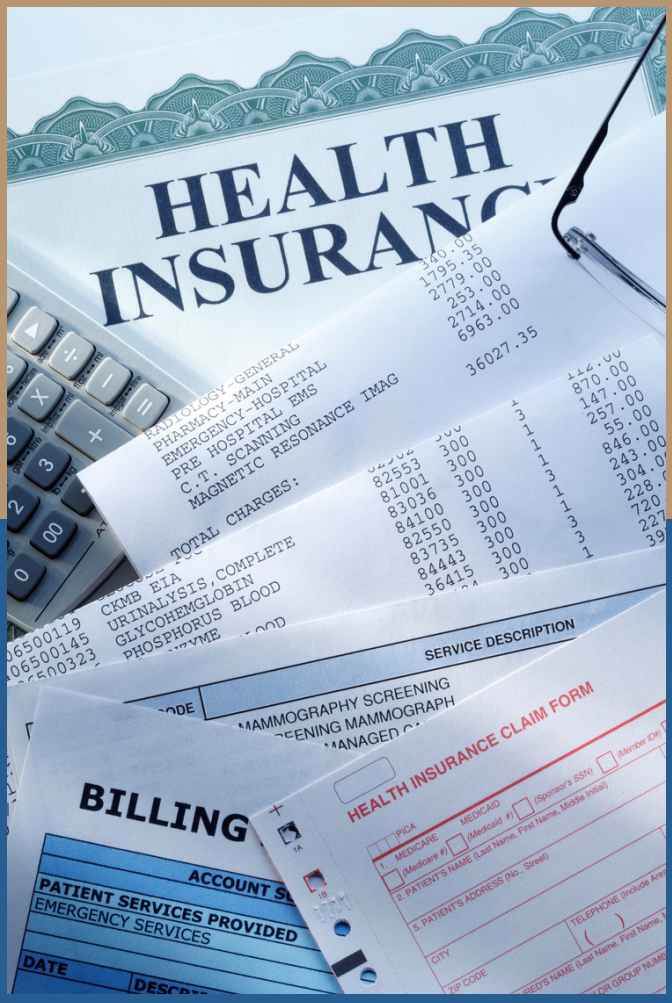

Understanding Your Health Insurance Options

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Insurance Terms/Definitions

- **Affordable Care Act (ACA) Preventive Services** - the ACA expanded access to preventive care by requiring that all insurers provide preventive services without cost sharing and by expanding access to coverage that included these preventive services. See pages 15 – 17 for a list of covered preventive services.

- **Allowed Amount** – (Also called Eligible Expenses, Payment Allowance, or Negotiated Rate.) The maximum amount a plan will pay for a covered health care service.

  √ In-Network Provider:

  ⇒ If you used a provider that's in-network with your health plan, the allowed amount is the discounted price your managed care health plan negotiated in advance for that service.

  ⇒ Usually, an in-network provider will bill more than the allowed amount, but he or she will only get paid the allowed amount. You don't have to make up the difference between the allowed amount and the actual amount billed when you use an in-network provider; your provider has to just write off whatever portion of their billed amount that's above the allowed amount.

  √ Out-of-Network Provider

  ⇒ If you used an out-of-network provider, the allowed amount is the price your health insurance company has decided is the usual, customary, and reasonable fee for that service. An out-of-network provider can bill any amount he or she chooses and does not have to write off any portion of it. Your health plan doesn't have a contract with an out-of-network provider, so there's no negotiated discount. But the amount your health plan pays—if any—will be based on the allowed amount, not on the billed amount.

- **Balance Billing** – If you see an Out-of-Network provider, they can bill you for the difference between the charged amount and the insurance carrier Allowed Amount. If you see an In-Network provider, they cannot bill you for this difference.

Insurance Terms/Definitions

- **Benefit Year** - The 12-month period for which health insurance benefits are calculated, not necessarily coinciding with the calendar year. Health insurance companies may update plan benefits and rates at the beginning of the benefit year.

- **Coinsurance** - Percentage of the medical cost you pay after your deductible has been met for many medical services such as surgery, x-rays, hospitalization.
  - √ For example, if your plan has coinsurance of 20 percent and you have met your deductible, a medical service that costs $1,000 will require you to pay $200.

- **Coordination of Benefits**—A system used in group health plans to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100% of the claim.
  - √ Be aware though that some plans state that they will not pay more as a secondary insurance than they would have paid had they been the primary insurance.
  - √ For example, if the primary insurance pays 80% of a claim and the secondary insurance normally only pays 80% of the claim, the secondary insurance may not pay anything.
  - √ In another example, the primary insurance pays 70% of a claim and the secondary insurance normally pays 80% of this type of claim - in this case the secondary insurance will pay 10% (the difference between what the primary insurance paid and what the secondary normally pays.)

- **Copayment (Copay)** - Set rate you pay for prescriptions, doctor visits, and some other types of care.
  - √ Some plans have a separate hospitalization copay that must be paid after the deductible.
  - √ The amount can vary by the type of service. For example, you may have a co-pay of $30 for a doctor's visit, $70 for a specialist visit, $20 for one kind of prescription, and $50 for another type of prescription.

Insurance Terms/Definitions

- **Deductible** - Amount you must pay before the plan pays toward the cost of a service.
  √ If out-of-network coverage is provided, there will be separate in-network and out-of-network deductibles, with the OON deductible being quite a bit higher. IN deductible payments count toward OON deductible limits, but OON deductible payments do not count toward IN deductible limits.
  √ Copayments may or may not count toward your deductible.
  √ Some plans have a separate prescription deductible.

- **Essential Health Benefits** - All plans offered in the Marketplace cover these 10 essential health benefits:

  √ Ambulatory patient services (outpatient care you get without being admitted to a hospital)
  √ Emergency services
  √ Hospitalization (like surgery and overnight stays)
  √ Pregnancy, maternity, and newborn care (both before and after birth)
  √ Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
  √ Prescription drugs
  √ Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
  √ Laboratory services
  √ Preventive and wellness services and chronic disease management
  √ Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)

  Plans must also include the following benefits:
  √ Birth control coverage
  √ Breastfeeding coverage

Insurance Terms/Definitions

- **FSA - Flexible Spending Accounts** – 2022 Contribution Limit $2,850.
  √ Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for certain eligible healthcare expenses (medical, dental, and vision) not covered by the employer's health plan. The employer may also make contributions to an FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money.

- **HRA – Health Reimbursement Account** – 2022 Excepted Benefit HRA (EBHRA) $1,800, Group Coverage HRA/Integrated HRA (GCHRA) No limit
  √ An HRA, or health reimbursement arrangement, is a kind of health spending account provided and owned by an employer. The money in it pays for qualified expenses, like medical, pharmacy, dental and vision, as determined by the employer.
  √ Other key things to know about HRAs are:
  ⇒ Only your employer can put money in an HRA
  ⇒ You don't pay taxes on money that comes from an HRA
  ⇒ Your employer decides whether to let unused funds roll over from one year to the next
  ⇒ Employers have more say in how HRAs work and have more options to choose from than other health spending accounts.
  ⇒ Employers not only decide what an HRA will pay for, they can decide when it pays (You pay first or HRA pays first), by choosing from different designs.

Insurance Terms/Definitions

- **HSA – Health Savings Account** – 2022 Contribution Limits $3,650 for Single coverage and $7,300 for Family coverage.
  - √ An HSA is a type of savings account that lets you set aside money on a pre-tax basis to pay for qualified healthcare expenses. By using untaxed dollars in a Health Savings Account (HSA) to pay for deductibles, copayments, coinsurance, and some other expenses, you may be able to lower your overall health care costs. HSA funds generally may not be used to pay premiums.
  - √ While you can use the funds in an HSA at any time to pay for qualified medical expenses, you may contribute to an HSA only if you are actively enrolled in a High Deductible Health Plan (HDHP)

- **In-Network (IN)** – Providers or facilities that are directly contracted with the insurance carrier and are part of the carrier service network.

- **LPFSA – Limited Purpose Flexible Spending Account** – 2022 Contribution Limit $2,850
  - √ A limited purpose flexible spending account (LPFSA) is a special type of flexible spending account (FSA) that may be available to consumers enrolled in a health savings account (HSA).
  - √ Consumers can use LPFSAs to pay for vision and dental expenses before they've met their insurance deductible. In some cases, an LPFSA can also be used for regular qualified medical expenses after you meet your deductible. However, this depends on the rules your employer has established for the LPFSA account that is offered.

Insurance Terms/Definitions

- **Mail Order Drug Plan** - Some plans may offer a mail-order program that allows you, or requires you, to get up to a 3-month supply of your covered prescription drugs sent directly to your home.
  - √ Mail-order medications are often less expensive. Mail-order pharmacies operate through your health plan, meaning that your insurer can buy medications in large quantities directly from drug manufacturers to lower costs. Mail-order prescriptions usually contain a 90-day bulk supply, which can save you money.
  - √ A 90-day supply means that your prescription needs to be filled less often, so it's less time and work for refills.
  - √ Many mail-order pharmacies offer 24/7 service through their website or by telephone. This is helpful if you have questions about your medication outside of business hours, when local pharmacies are closed.

- **Medical Necessity** - Medical necessity refers to a decision by your health plan that your treatment, test, or procedure is necessary to maintain or restore your health or to treat a diagnosed medical problem. Generally, medically necessary services include those that are:
  - √ Accepted by medical standards
  - √ Appropriate and necessary to treat, cure, relieve or diagnose an injury, illness, disease or condition
  - √ Provided to treat, cure, relieve or diagnose an injury, illness, disease or condition (not including clinical trial or experimental, cosmetic or investigative services)
  - √ Often, policies factor in costs, settings and alternative services, as well.

- **Out-of-Network (OON)** - Providers or facilities that do not have a contract with the insurance carrier. This can result in higher cost to patients.

- **Out-of-Pocket Maximum** – the most money you will pay during a year for coverage. It includes deductibles, copayments, and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Insurance Terms/Definitions

- **Prescription Tiers/Formulary** - A formulary is a list of prescription medications, both generic and brand-name, covered by your insurance plan. Prescription medications are grouped into tiers, and the tier your medication is on determines your portion of the cost. Tier 1 usually covers generic medications, making this the lowest-cost tier. Higher tiers cover preferred and non-preferred brand-name medications at a higher cost to you. If your medication is not included on a formulary tier, it is not covered by a plan.

- **Primary Care Physician (PCP)** - A primary care physician is a medical doctor who's trained to prevent, diagnose, and treat a broad array of illnesses and injuries in the general population. Some types of medical plans require you to select a PCP who will coordinate all your health care services.

- **Primary versus Secondary Insurance**
  - √ Primary insurance is a health insurance plan that covers a person as an employee, subscriber, or member. Primary insurance is billed first when you receive health care. For example, health insurance you receive through your employer is typically your primary insurance.
  - √ Secondary insurance is a health insurance plan that covers you in addition to your primary insurance plan. Typically, secondary insurance is billed when your primary insurance plan is exhausted and may help cover additional health care costs. For example, if you already have insurance through your employer and choose to enroll with your spouse's health insurance plan (if allowed), that coverage would become your secondary insurance.

Insurance Terms/Definitions

- **Qualifying Life Event (QLE)**

a. Because medical benefit payroll deductions are paid on a pre-tax basis, the law restricts when a employee can make benefit elections or changes. Employees can elect or change their coverage choice when they first become eligible, during the annual open enrollment period, or if they have a qualifying life event.

b. A qualifying life event is s change in your situation — like getting married, having a baby, or losing health coverage — that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the yearly Open Enrollment Period.

c. Election changes must be made within a time frame designated by your employer. Most employers set a 30-day rule meaning that you must make any benefit changes within 30 days of the qualifying life event. There are 4 main categories of life events:

1. Loss of health coverage
   - Losing existing health coverage, including job-based, individual, and student plans
   - Losing eligibility for Medicare, Medicaid, or CHIP
   - Turning 26 and losing coverage through a parent's plan
2. Changes in household
   - Getting married or divorced
   - Having a baby or adopting a child
   - Death in the family
3. Changes in residence
   - Moving to a different ZIP code or county
   - A student moving to or from the place they attend school
4. Other qualifying events
   - Changes in your income that affect the coverage you qualify for
   - Becoming a U.S. citizen

Types of Medical Plans

HMO - Health Maintenance Organization

A Health Maintenance Organization is a network of doctors, hospitals and other health care providers who agree to provide care at a reduced rate. To keep costs low, HMOs require you to select a primary care physician (sometimes called a primary care provider or PCP), who can refer you to specialists when needed.

An HMO plan will only pay for care from health care providers in the HMO network, except for emergency care, which may be covered out-of-network. Lab work, such as a blood draw, or a urine test, is also limited to one laboratory provider covered by the HMO network.

HMO plans are generally less expensive than PPO plans, with lower monthly payments, making them ideal if your favorite doctors are already in the network, or if you receive most of your care close to home.

POS - Point of Service

A point-of-service plan (POS) is a type of managed care plan that is a hybrid of HMO and PPO plans. Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for health care services. When patients venture out of the network, they'll have to pay most of the cost, unless the primary care provider has made a referral to the out-of-network provider.

EPO - Exclusive Provider Organization

Like HMOs, EPOs cover only in-network care, but networks are generally larger than for HMOs, but smaller than PPOs. They may or may not require referrals from a primary care physician. Premiums are higher than HMOs, but lower than PPOs.

An EPO plan often requires you to pay more out of pocket before your insurance starts covering your medical expenses, but EPOs may also offer lower monthly premiums because the providers in your network have contracts with your insurance company.

Types of Medical Plans

PPO – Preferred Provider Organization

Like an HMO, a Preferred Provider Organization is a network of doctors, hospitals and health care providers who agree to provide care at a certain rate. Unlike an HMO, you are not limited to providers who are in-network, though your copay or out-of-pocket cost for out-of-network visits may be higher than for in-network providers.

PPO plans typically require higher monthly payments/per paycheck deduction in exchange for increased flexibility. With a PPO, you do not need to maintain a primary care physician, and can see a different doctor of your choice at any time, including specialists. This also means when you are traveling, you can receive care wherever you are.

Additionally, PPO plans offer more options for laboratory service providers. When you need lab work done, you can choose the most convenient location under a PPO network.

HDHP – High Deductible Health Plan

HDHPs cover certain preventive care before the deductible – the ACA requires this of all plans – but under an HDHP, no other services can be paid for by the health plan until the insured has met the deductible. That means HDHPs cannot have copays for office visits or prescriptions prior to the deductible being met.

The IRS defines a high deductible health plan as any plan with a deductible of at least $1,400 for an individual or $2,800 for a family. An HDHP's total yearly out-of-pocket expenses (including deductibles, copayments, and coinsurance) can't be more than $7,050 for an individual or $14,100 for a family.

Medical Plan Comparison Chart

	HMO	POS	EPO	PPO	HDHP
Low or No Deductible	√	√			
Premiums	$$	$$$	$$$	$$$$	$
Primary Care Physician (PCP) Must be Selected	√	√	Some plans		
Referrals Required	√	√			
Out-of-Network Coverage Provided		√		√	√
Copayments for Common Services (i.e. Doctor's Visit, Prescriptions)		√	√	√	
Deductible Must be Met Before Plan Pays for SOME Services (i.e. Hospitalization, Out-Patient Surgery)		√	√	√	
Deductible Must Be Met Before Plans Pays for ANY Services					√
Contributions to an HSA Allowed?					√
IRS Minimums on Deductibles and Out-of-Pocket Maximums					√
Eligible to contribute to an FSA	√	√	√	√	
Eligible to contribute to an HSA					√
Eligible to contribute to a Limited Purpose FSA					√

What is the Difference Between an FSA, Limited Purpose FSA, HSA, and HRA?

	HSA	HRA	FSA	Limited Purpose FSA
Can you or your company contribute if you have an HMO medical plan?		√	√	
Can you or your company contribute if you have an POS medical plan?		√	√	
Can you or your company contribute if you have an EPO medical plan?		√	√	
Can you or your company contribute if you have an PPO medical plan?		√	√	
Can you or your company contribute if you have an HDHP medical plan?	√			√
Can you or your company contribute if you are enrolled in Medicare?		√	√	
You own the account.	√			
Your employer owns the account.		√	√	√
You must have a high-deductible health plan.	√			√
You and your employer can put money in.	√		√	√
Only your employer can put money in.		√		
Unused Funds…	Carry over from year to year	Returned to employer	Forfeited	Forfeited
Funds are available…	After they have been withheld from paycheck or deposited by employer	After they have been deposited by employer	On the first day of the plan year	On the first day of the plan year
You can invest the money in the account.	√			
Must report account when you do your taxes.	√	√	Only if employer contributes to account	Only if employer contributes to account

Where Can You Get Health Insurance?

Depending on your age, job status, and financial condition, there are many ways that you can get health insurance, including:

1. **Health insurance provided by an employer.** Large companies in the U.S. are required to provide affordable health insurance as an employee benefit (or face a penalty), and many small employers also offer coverage to their workers. You will likely be required to pay some portion of the monthly premium, or cost of the health insurance, particularly if you add your family to your plan. But most employers that offer health coverage do tend to pay the majority of the premiums.

2. **Health insurance that you purchase on your own.** If you are self-employed or work for a small company that does not provide health insurance, you will need to buy it on your own. You can get it through the health insurance exchange in your state, or directly from an insurance company, but premium subsidies (to lower the amount you have to pay for your coverage) and cost-sharing subsidies (to lower the amount you have to pay when you need medical care) are only available if you get your coverage through the exchange.

   (Note that in most areas, there are also plans available for self-purchase that aren't compliant with the Affordable Care Act, such as short-term health insurance, fixed indemnity plans, health care sharing ministry plans, direct primary care plans, etc. But in general, these are never suitable to serve as stand-alone coverage for any significant length of time.)

3. **Health insurance provided by the government.** If you are 65 or older, disabled, or have little or no income, you may qualify for health insurance provided by the government, such as Medicare or Medicaid. Children, and in some states, pregnant women, are eligible for CHIP with household incomes that can extend well into the middle class. Depending on the coverage and your circumstances, you may or may not have to pay monthly premiums for your government-sponsored health coverage.

What Things Do You Need To Take Into Consideration When Selecting a Medical Plan, Whether an Employer-Sponsored Plan, a State or Federal Exchange Plan, or an Individual plan?

1. The type of plan and the provider network.
    a. Does the plan provide in-network AND out-of-network (OON) coverage?
    b. Are your providers in the network?
    c. Does the plan cover the medications that you take (generic and brand)?
    d. Will you be required to select a primary care physician and obtain referrals to see a specialist?
    e. Do you travel a lot and potentially need access to non-emergency medical care while travelling?

2. Premiums or Payroll Contributions.
    a. Premiums or payroll contributions are the amount you pay an insurance company for coverage, whether or not you use medical and pharmacy services.

3. What will your out-of-pocket expenses be?
    a. Deductibles - What is the amount you have to pay out-of-pocket before your coverage kicks in?
    b. Will you pay flat amounts (copays) or percentages of service cost (coinsurance)?
    c. What is the plan out-of-pocket maximum?

4. Do you (and your family if they will be covered) have medical conditions that require ongoing doctor visits, tests, prescription, or procedures?

5. Do you have any expected upcoming medical situations or procedures scheduled (i.e. pregnancy, knee replacement, etc.)

6. Prescription Coverage - Does the plan have a limited formulary or an open formulary?

Which Type of Plan May Be Best For You?

Higher premiums, more coverage

In general, the higher your premium, the lower your out-of-pocket costs such as copays and coinsurance (and vice versa). A plan that pays a higher portion of your medical costs, but has higher monthly premiums, may be better if:

1. You see a primary physician or a specialist frequently.
2. You frequently need emergency care.
3. You take expensive or brand-name medications on a regular basis.
4. You're expecting a baby, plan to have a baby or have small children.
5. You have a planned surgery coming up.
6. You've been diagnosed with a chronic condition such as diabetes or cancer.

Lower premiums, higher out-of-pocket

A plan with higher out-of-pocket costs and lower monthly premiums might be the better choice if:

1. You can't afford the higher monthly premiums for a plan with lower out-of-pocket costs.
2. You're in good health and rarely see a doctor.

Selecting the best health insurance plan to fit your needs can be a challenging process. But it's important to review your options each year during open enrollment, to make sure you've noticed any changes for the coming year and considered any new plans that might be available. It might be tempting to just let your current plan auto-renew, but that's never in your best interest.

Preventive Screenings Covered at 100% With No Deductible, Copays, or Coinsurance (as of 2022)

All Adults Age 18 and Over

Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked
Alcohol misuse screening and counseling
Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
Blood pressure screening
Cholesterol screening for adults of certain ages or at higher risk
Colorectal cancer screening for adults 45 to 75
Depression screening
Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
Diet counseling for adults at higher risk for chronic disease
Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting
Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
Hepatitis C screening for adults age 18 to 79 years
HIV screening for everyone age 15 to 65, and other ages at increased risk
PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use
Immunizations for adults — doses, recommended ages, and recommended populations vary: • Chickenpox (Varicella) • Diphtheria • Flu (influenza) • Hepatitis A • Hepatitis B • Human Papillomavirus (HPV) • Measles • Meningococcal • Mumps • Whooping Cough (Pertussis) • Pneumococcal • Rubella • Shingles • Tetanus
Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
Obesity screening and counseling
Sexually transmitted infection (STI) prevention counseling for adults at higher risk
Statin preventive medication for adults 40 to 75 at high risk
Syphilis screening for adults at higher risk
Tobacco use screening for all adults and cessation interventions for tobacco users
Tuberculosis screening for certain adults without symptoms at high risk

Preventive Screenings Covered at 100% With No Deductible, Copays, or Coinsurance (as of 2022)

Women

Services for pregnant women or women who may become pregnant
Breastfeeding support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
Birth control: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers." Learn more about contraceptive coverage.
Folic acid supplements for women who may become pregnant
Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes
Gonorrhea screening for all women at higher risk
Hepatitis B screening for pregnant women at their first prenatal visit
Maternal depression screening for mothers at well-baby visits (PDF, 1.5 MB)
Preeclampsia prevention and screening for pregnant women with high blood pressure
Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
Syphilis screening
Expanded tobacco intervention and counseling for pregnant tobacco users
Urinary tract or other infection screening
Other covered preventive services for women
Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause
Breast cancer genetic test counseling (BRCA) for women at higher risk
Breast cancer mammography screenings - Every 2 years for women 50 and over - As recommended by a provider for women 40 to 49 or women at higher risk for breast cancer
Breast cancer chemoprevention counseling for women at higher risk
Cervical cancer screening - Pap test (also called a Pap smear) for women age 21 to 65
Chlamydia infection screening for younger women and other women at higher risk
Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
Domestic and interpersonal violence screening and counseling for all women
Gonorrhea screening for all women at higher risk
HIV screening and counseling for everyone age 15 to 65, and other ages at increased risk
PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative women at high risk for getting HIV through sex or injection drug use
Sexually transmitted infections counseling for sexually active women
Tobacco use screening and interventions
Urinary incontinence screening - for women yearly
Well-woman visits to get recommended services for all women

Preventive Screenings Covered at 100% With No Deductible, Copays, or Coinsurance (as of 2022)

Infants and Children Under Age 18

Alcohol, tobacco, and drug use assessments for adolescents
Autism screening for children at 18 and 24 months
Behavioral assessments for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
Bilirubin concentration screening for newborns
Blood pressure screening for children: Age 0 to 11 months, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years
Blood screening for newborns
Depression screening for adolescents beginning routinely at age 12
Developmental screening for children under age 3
Dyslipidemia screening
Fluoride supplements for children without fluoride in their water source
Fluoride varnish for all infants and children as soon as teeth are present
Gonorrhea preventive medication for the eyes of all newborns
Hearing screening for all newborns; and regular screenings for children and adolescents as recommended by their provider
Height, weight and body mass index (BMI) measurements
Hematocrit or hemoglobin screening for all children
Hemoglobinopathies or sickle cell screening for newborns
Hepatitis B screening for adolescents at higher risk
HIV screening for adolescents at higher risk
Hypothyroidism screening for newborns
PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
Immunizations for children from birth to age 18 — doses, recommended ages, and recommended populations vary: • Chickenpox (Varicella) • Diphtheria, tetanus, and pertussis (DTaP) • Haemophilus influenza type b • Hepatitis A • Hepatitis B • Human Papillomavirus (HPV) • Inactivated Poliovirus • Influenza (flu shot) • Measles • Meningococcal • Mumps • Pneumococcal • Rubella • Rotavirus
Lead screening for children at risk of exposure
Obesity screening and counseling
Oral health risk assessment for young children from 6 months to 6 years
Phenylketonuria (PKU) screening for newborns
Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
Tuberculin testing for children at higher risk of tuberculosis: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
Vision screening for all children
Well-baby and well-child visits

Common Questions Related to Health Insurance

1. There has been a lot of confusion and misinformation around the ACA Healthcare Mandate. What is the current policy?

a. Full name is the Patient Protection and Affordable Care Act but is referred to as the "Affordable Care Act" or "ACA" for short.

b. Three main goals of the original act were:

(1) Make insurance affordable by providing lower income households, those with household incomes of between 100% and 400% of the federal poverty level) with subsidies to offset the cost of health insurance provided through the Federal Marketplace,

(2) Expand the Medicaid program to cover adults below 138% of the federal poverty level (this part of the law was left up to each individual state and not all states expended their Medicaid eligibility limits.)

(3) Implement an innovative medical care delivery method designed to lower the costs of healthcare by helping become more conscious and informed healthcare users.

c. Originally the ACA Healthcare Mandate, which was part of the over ACA policy required all individuals to have health insurance or pay a tax penalty. This portion of the ACA regulations was eliminated in 2019.

d. Some great benefits that came from the passing of ACA include:

(1) Elimination of the pre-existing condition clause included in many insurance carrier policies. The pre-existing condition clause allowed an insurance company to deny you coverage or carve-out coverage you're your pre-existing condition. Prior to ACA, health insurers can no longer charge more or deny coverage to you or your child because of a pre-existing health condition like asthma, diabetes, or cancer, as well as pregnancy. They cannot limit benefits for that condition either. Once you have insurance, they can't refuse to cover treatment for your pre-existing condition.

(2) Prior to ACA, my insurance plans dropped dependents when they turned 19 or age 23 if they were a full-time student. With ACA, any dependent can remain on a parent's insurance until their 26th birthday.

Common Questions Related to Health Insurance

1. There has been a lot of confusion and misinformation around the ACA Healthcare Mandate. What is the current policy? (Answer cont'd)

(3) Medical plans prior to ACA usually had annual and lifetime limits on how much the plan would cover, for example, many had $1M lifetime limits on coverage. This meant that if your medical claims exceeded $1M during the time you were covered, the plan would stop paying any claims. With ACA, plans can no longer put annual or lifetime limits on 12 “essential health benefits” such as: emergency care, prescription drugs, lab services, etc.

(4) Coverage of many preventive services for children, men, and women must be covered at 100% with no cost to the patient.

2. If I am a part-time or contract employee, do companies have to offer me healthcare coverage?

ACA requires employers to provide coverage to full-time employees but does not require them to provide benefits for part-time employees. A full-time employees is Any employee who works an average of at least 30 hours per week for more than 120 days in a year. Part-time employees work an average of less than 30 hours per week. Independent contractors are not considered employees and are therefore not eligible for employer benefits.

3. Do most health benefits offered by companies include dental and vision, or are those extra?

Employer provided medical benefits do not cover dental and vision benefits. However, to be in compliance with ACA, small employers (those with less than 50 employees) must provide the option to purchase pediatric dental benefits. Most employers, regardless of their size, do offer the option to purchase dental and vision coverage.

Common Questions Related to Health Insurance

4. Can you explain about the different types of spending and savings accounts that an employer may offer and talk about whether my employer see or do they get a report on what I spent my money on?

First off, there are 4 different types of spending and savings accounts that an employer can offer.

Flexible Spending Account or FSA - 2022 Contribution Limit $2,850.
Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for certain eligible healthcare expenses (medical, dental, and vision) not covered by the employer's health plan. The employer may also make contributions to an FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money.

LPFSA – Limited Purpose Flexible Spending Account – 2022 Contribution Limit $2,850
A limited purpose flexible spending account (LPFSA) is a special type of flexible spending account (FSA) that may be available to consumers enrolled in a health savings account (HSA). Consumers can use LPFSAs to pay for vision and dental expenses before they've met their insurance deductible. In some cases, an LPFSA can also be used for regular qualified medical expenses after you meet your deductible. However, this depends on the rules your employer has established for the LPFSA account that is offered.

HSA – Health Savings Account – 2022 Contribution Limits $3,650 for Single coverage and $7,300 for Family coverage.
Savings account that lets you set aside money on a pre-tax basis to pay for qualified healthcare expenses. You can use an HSA to pay for deductibles, copayments, coinsurance, and some other expenses. While you can use the funds in an HSA at any time to pay for qualified medical expenses, you may contribute to an HSA only if you are actively enrolled in a High Deductible Health Plan (HDHP.)

Common Questions Related to Health Insurance

4. Can you explain about the different types of spending and savings accounts that an employer may offer and talk about whether my employer see or do they get a report on what I spent my money on? (Answer cont'd)

HRA – Health Reimbursement Account – 2022 Excepted Benefit HRA (EBHRA) $1,800, Group Coverage HRA/Integrated HRA (GCHRA) No limit
An HRA, or health reimbursement arrangement, is a kind of health spending account provided and owned by an employer. The money in it pays for qualified expenses, like medical, pharmacy, dental and vision, as determined by the employer.

Other key things to know about HRAs are:
⇒ Only your employer can put money in an HRA
⇒ You don't pay taxes on money that comes from an HRA
⇒ Your employer decides whether to let unused funds roll over from one year to the next
⇒ Employers have more say in how HRAs work and have more options to choose from than other health spending accounts.
⇒ Employers not only decide what an HRA will pay for, they can decide when it pays (You pay first or HRA pays first), by choosing from different designs.

To ensure patient confidentiality, almost all employers contract with an outside vendor to manage their spending or savings account program. This outside vendor will have access to what you spent the money on as they need to verify that it was spent on approved items or services. The employer however will only receive notification of the amount you spent, not what you spent the money on.

Common Questions Related to Health Insurance

5. Are employers required to offer coverage to family members? If yes, who qualifies as a family member?

a. Under the Affordable Care Act, employers that are consider Applicable Large Employers or ALE (generally 50 full-time employees including full-time equivalent employees, which means a combination of part-time employees that count as one or more full-time employees) are required to provide dependent coverage but they are not required to provide spouse coverage.

b, However, most, especially larger employers do offer spouse coverage. Some employers have added restriction or surcharges for employers who cover a spouse when that spouse has their own employer coverage available to them.

c. Under ACA the definition of a dependent is a child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction.

d. Some employers that offer spouse coverage may provide this benefit to just opposite sex legal spouse while others may offer it to both same or opposite sex legal spouses.

6. Suppose I enroll in my company's plan. Should I enroll with my spouse's plan, too, to get more coverage?

a. When you are covered under more than one health plan, coordination of benefit rules come into play.

b. Coordination of Benefits is a process used in group health plans to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100% of the claim. Most plans state they will not pay more as a secondary insurance than they would have paid had they been the primary insurance.

√ For example, if the primary insurance pays 80% of a claim and the secondary insurance normally only pays 80% of the claim, the secondary insurance may not pay anything.

√ In another example, the primary insurance pays 70% of a claim and the secondary insurance normally pays 80% of this type of claim - in this case the secondary insurance will pay 10% (the difference between what the primary insurance paid and what the secondary normally pays.)

Common Questions Related to Health Insurance

7. If I join my company and choose an HMO, then decide to change to a PPO, how long do I have to wait to make that change?

a. Because medical benefit payroll deductions are paid on a pre-tax basis, the law restricts when a employee can make benefit elections or changes. Employees can elect or change their coverage choice when they first become eligible, during the annual open enrollment period, or if they have a qualifying life event.

b. A qualifying life event is s change in your situation — like getting married, having a baby, or losing health coverage — that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the yearly Open Enrollment Period.

c. Election changes must be made within a time frame designated by your employer. Most employers set a 30-day rule meaning that you must make any benefit changes within 30 days of the qualifying life event.

d. There are 4 main categories of life events:

(1) Loss of health coverage

(a) Losing existing health coverage, including job-based, individual, and student plans

(b) Losing eligibility for Medicare, Medicaid, or CHIP

(c) Turning 26 and losing coverage through a parent's plan

(2) Changes in household

(a) Getting married or divorced

(b) Having a baby or adopting a child

(c) Death in the family

(3) Changes in residence

(a) Moving to a different ZIP code or county

(b) A student moving to or from the place they attend school

(4) Other qualifying events

(a) Changes in your income that affect the coverage you qualify for

(b) Becoming a U.S. citizen

Common Questions Related to Health Insurance

8. How do I know which plan is best?

a. The type of plan and the provider network
   (1) Does the plan provide in-network AND out-of-network (OON) coverage?
   (2) Are your providers in the network?
   (3) Does the plan cover the medications that you take (generic and brand)?
   (4) Will you be required to select a primary care physician and obtain referrals to see a specialist?
   (5) Do you travel a lot and potentially need access to non-emergency medical care while travelling?

b. Premiums or Payroll Contributions
   (1) Premiums or payroll contributions are the amount you pay an insurance company for coverage, whether or not you use medical and pharmacy services.

c. What will your out-of-pocket expenses be?
   (1) Deductibles - What is the amount you have to pay out-of-pocket before your coverage kicks in?
   (2) Will you pay flat amounts (copays) or percentages of service cost (coinsurance)?
   (3) What is the plan out-of-pocket maximum?
   (4) Do you (and your family if they will be covered) have medical conditions that require ongoing doctor visits, tests, prescription, or procedures?
   (5) Do you have any expected upcoming medical situations or procedures scheduled (i.e. pregnancy, knee replacement, etc.)
   (6) Prescription Coverage - Does the plan have a limited formulary or an open formulary?

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