

Deadline: March 31, 2014

The New Health Care Law and You

The Affordable Care Act (ACA) is the new law that requires everyone to get health insurance, and there are some new health insurance choices starting in October 2013.





Health Insurance Is Important!

The more you understand about how your health insurance works and the specific details of your plan, the better you will be able to understand and use it.

There are 4 questions that everyone needs to ask in order to be ready for this new law, and this guide will help you begin to find answers to the 4 questions.





What are my choices for health insurance?

Your choices are based on knowing the answers to these questions:

- How old am I?
- What state do I live in?
- Can I get insurance through my job?
- Can I get insurance through my spouse, parent/legal guardian, or school?
- Am I a U.S. citizen, U.S. national, or legal U.S. resident?
- How much do I make a year, and how does it compare to the federal poverty level (FPL)?
- Have I served or am I serving in the U.S. armed services?
- Am I pregnant?
- Do I have one of the following: End Stage Renal Disease (ESRD), Lou Gehrig's disease (ALS), a disability, or legal blindness?





Medicaid

Medicaid is mostly for **kids, pregnant women, people who don't make a lot of money, and people who are disabled.**

If you make less than a certain amount of money each year, you can get Medicaid for you and your kids. If you get insurance through your job, most states won't allow you to get Medicaid. The state where you live sets the rules for Medicaid.

Medicaid is called different names in different states. Find out what it is called in your state.

Medicaid might be for you if...

- you are under 18 years old.
- you are pregnant.
- you became disabled within the past 2 years.
- you are the parent of a child under 18 years old.
- you take care of someone who is disabled.
- you are an adult who makes less than a certain amount of money, which is different in every state.



Where can I get more information?

www.medicaid.gov

Children's Health Insurance Program (CHIP)

CHIP is mostly for kids. In some states, if you are pregnant you can also get CHIP.

CHIP might be for you if...

- you work, but you can't get insurance through your job.
- you make too much money to qualify for Medicaid.

CHIP is called different names in different states. Find out what it is called in your state.

Where can I get more information?

www.insurekidsnow.gov

1-877-KIDS-NOW (1-877-543-7669)

Medicare

Medicare is for people who are at least 65 years old. It is also for people who have been disabled for more than 2 years – we call these long-term disabilities. Medicare might be best if you are over 65 years old, have been a U.S. citizen or permanent resident for at least 5 years, worked in the U.S. for at least 10 years, and paid Medicare taxes (or you have been married to someone who has).



Medicare might be best if you have been receiving disability from Social Security for at least 2 years, or you have ALS (Lou Gehrig's Disease), ESRD (End Stage Renal Disease), or are on dialysis.

What does Medicare cover?

It depends on which parts you sign up for.

Medicare has 4 Parts: A, B, C, and D. You can also sign up for extra health care choices through Medigap.

Most people sign up for Parts A & B. Consider signing up for Part D so that you will have coverage for prescription medicine. Some people who want to have Medicare through private insurance decide to sign up for Part C (Medicare Advantage).



Medicare Part A covers hospital stays, nursing home stays, hospice care, and home health care.

Medicare Part B covers doctor visits, home health care, medical equipment (like crutches), and mental health care.

Medicare Prescription Drug Plan (Part D) covers prescription medicines.

Medicare Advantage (Part C) is like Medicare, but through private insurance companies. It depends on your plan, but most cover the same services as Parts A & B.

Medigap covers other services not covered by other parts of Medicare, including eye and dentist visits. Check your Medigap plan.

Where can I get more information?

www.medicare.gov

1-800-MEDICARE (1-800-633-4227)



Some people may also be able to get care through TRICARE, the Indian Health Service or the VA. These are not health insurance plans, but places to get care.

TRICARE

TRICARE is healthcare for active or retired members of the military (people in the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, or the National Oceanic and Atmospheric Administration).

TRICARE might be for you if...

- you are in the military right now or retired from the military.
- you are married to someone who is in the military right now.
- you are the child of someone in the military right now, and you are not married.
- you are the spouse or child of someone who died while in the military.
- you are a reserve member of the military who has been active for more than 30 days in a row.
- you are the spouse or child of someone who is retired from the military.

What does TRICARE cover?

Depending on which TRICARE plan you have, costs and coverage may vary.

Where can I get more information?

www.tricare.mil

Talk to your commanding officer.



Indian Health Service (IHS)

American Indians and Alaska Natives can get medical care through the IHS. The IHS mostly serves people who live on or near reservations or in rural areas.



What does the IHS offer?

Health services are provided at specific IHS health centers. This could be a hospital, a “health station,” an urban Indian health project, or an Alaskan village clinic.

Where can I get more information?

www.ihs.gov

1-800-IHS-CARE (1-800-447-2273)

The VA – Veterans Health Administration

The VA is the health system for **military veterans** (from the Army, Navy, Marines, Air Force, or Coast Guard). All veterans should apply to the VA to determine eligibility.

The VA might be the choice for you if...

- you served in the military for at least 2 years and were honorably discharged.
- you were called to active duty while you were in the military.
- you are married to someone who was permanently disabled during their military service.
- you are married to someone who died during their military service.
- you are the unmarried child of someone who was permanently disabled during their military service.
- you are the unmarried child of someone who died while in the military.

What does the VA offer?

The VA offers many health care services including hospitals, clinics and nursing homes. Vets will need to go to a VA Health Center for care.

Where can I get more information?

www.va.gov

1-877-222-VETS (1-877-222-8387), or go to your local VA.





Employer-Sponsored Insurance (ESI)

ESI is offered through your job. Workers pay part of the price of the insurance, but most of your insurance is paid for by the company that you work for.

ESI might be best if...

- you work for a company that offers insurance to its workers.
- you are married to someone who works for a company that offers insurance.
- you are under 26 years old and your parent works for a company that offers insurance.

What does ESI cover?

It depends on what kind of plan you have. Most ESI plans cover preventive care, hospital stays and doctor visits. Many also cover prescription medicines.

- Many employers give their workers a chance to pay extra for more services, like dentist visits or eye care.
- Your company should let you know about your options when you are first hired and every year you work for them.

What are some types of ESI?

HMO: Health Maintenance Organizations -uses a network of doctors; requires a primary care physician.

PPO: Preferred Provider Organizations- uses a network of doctors; if you go out-of- network, it will cost more.

POS: Point of Service- uses a network of doctors; does not require referrals to specialists; if you go out-of-network, it will cost more.

Where can I get more information?

Every company's health insurance is a little bit different. Talk to your company's human resources or benefits person.



Health Insurance Marketplace (Health Exchange)

The Insurance Marketplace is a way to “shop” for different insurance plans. You can find insurance that fits your budget and compare different plans to find out which one best fits your needs. You can start to enroll in October 2013. If you do not qualify for any other type of insurance, you should buy insurance from the Marketplace. Every state will have a Marketplace.

If you are an individual or a family, the only requirements to get insurance through the Marketplace are that ...

- you must live in the U.S.
- you must be a U.S. citizen, a U.S. national, or a legal U.S. resident.
- you can't be in prison or jail.
- your employer does not offer you Employer-Sponsored Insurance or you can't afford it.

If you are a small business owner, you will be able to offer your employees new health plan choices through the Small Business Health Options Program (SHOP).

What does Marketplace insurance cover?

It depends on what kind of plan you choose. Each plan in the Marketplace will clearly list what is covered and how much it will cost.

Where can I get more information?

- Go to www.healthcare.gov to find out what kind of Marketplace your state will have.
- A 1-800 hotline will be available soon.
- Starting in October 2013, you will be able to enroll on the website or by calling the 1-800 hotline.
- Each state will provide people called **Patient Navigators** that can help you make your way through the system.





How much money you make affects your health choices.

The “Federal Poverty Level” (FPL)

What is the FPL and why does it matter?

The FPL is the smallest amount of money the government says you & your family need in order to pay for the basics: a place to live, food, and clothes. It includes the money you make at your job, plus money you have saved. The government changes the FPL each year.

The government and the state you live in use the FPL to decide if you qualify for certain programs (examples may include drugs for HIV/AIDS, birth control, and food stamps).

You need to know how the state you live in defines the FPL, and where you may fit into this scale. Each state can be very different. Here is a website that can help you figure out where you and your family fit on the FPL scale:

laborcenter.berkeley.edu/healthpolicy/calculator



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How Do I Get It?

Medicaid - How do I get it?

Every state is different. You should call your state's Medicaid office for more information about applying.

Go to www.cwla.org/programs/health/healthstate.htm to find the toll-free number for your state's Medicaid office.

In some states, you can apply for Medicaid online. In others, you can apply for Medicaid at your local:

- social services office
- health department
- Social Security office



CHIP - How do I get it?

- Call 1-877-KIDS-NOW (1-877-543-7669)
- Go to www.insurekidsnow.gov

What do I need to bring with me when I apply for Medicaid or CHIP?

Each state is different, but in general you should bring...

- your birth certificate or U.S. passport.
- photo ID (driver's license, state ID card, school ID card, military ID card).
- something that proves you live at your address – like a water, power, or gas bill, or a copy of your lease with your name on it.
- something that shows your Social Security Number (SSN).
- something that shows how much money you make (a paycheck; an income tax return; or letters from Social Security, Supplemental Security Income (SSI), and/or the VA).

If you are unemployed, got hurt at work, get child support, or have money saved for retirement, you should bring papers that show how much money you get from each.

If you're pregnant, some states require that you bring a letter from your doctor proving that you are pregnant.

If you have health insurance, bring your insurance card.

Medicare - How do I get it?

Sometimes you are automatically enrolled in Medicare Parts A&B, but sometimes you have to sign up yourself. Nobody is automatically enrolled in Part D or Medicare Advantage.

You will automatically be signed up for Parts A & B if you...

- are turning 65 and already get benefits from Social Security or the Railroad Retirement Board (RRB).
- are under 65 and have a disability.
- have ALS (Lou Gehrig's disease).

You will need to sign up for Parts A & B if you...

- are turning 65 and don't already receive Social Security or RRB benefits.
- have End-Stage Renal Disease (ESRD).

The different parts have different enrollment periods and different ways to sign up. To avoid paying a penalty, sign up as soon as you are eligible.





Medicare Parts A & B - How do I sign up?

- Apply online at Social Security: www.socialsecurity.gov/medicareonly
- Call Social Security: 1-800-772-1213
- Go to your local Social Security office. Before you go, be sure to call and ask what you need to bring with you.
- If you worked for a railroad, call the RRB: 1-877-772-5772

Here are the time frames to sign up for Parts A & B:

Initial enrollment period (the period when you can first sign up for Medicare)	Generally 3 months before to 3 months after the month you turn 65. For example, if your birthday is on June 15, your window for signing up is March 1 - September 30.
General enrollment period (the period every year when you can sign up for Parts A & B only, if you miss initial enrollment)	January 1 – March 31 of each year
Open enrollment period (the period every year when you can make any changes to your Medicare)	October 15 – December 7 of each year

If you miss your initial enrollment period, you will have to pay a penalty unless you are still working and have Employer-Sponsored Insurance.

What do I need to bring with me to sign up for Parts A & B?

You should bring...

- your birth certificate or U.S. passport.
- photo ID (driver's license, state ID card, school ID card, military ID card).
- something that proves you live at your address – like a water, power, or gas bill, or a copy of your lease with your name on it.
- something that shows your Social Security Number (SSN).
- something that shows how much money you make (a paycheck; an income tax return; or letters from Social Security, Supplemental Security Income (SSI), and/or the VA).

The image shows a close-up of a red pen with a silver clip resting on a Medicare Enrollment Form. The form is titled "Medicare Enrollment Form" and contains various fields for personal information. Visible fields include: "GROUP HEALTH PLAN (SSN or ID)" with a checkbox, "FECA (SSN)" with a checkbox, "OTHER (ID)" with a checkbox, "3. PATIENT'S BIRTH DATE" with fields for MM, DD, and YY, "SEX" with checkboxes for M and F, "1a. INSURED'S I.D.", "4. INSURED'S NA", "PATIENT RELATIONSHIP TO INSURED" with checkboxes for Self, Spouse, Child, and Other, and "7. INSURED'S A".



Prescription Drug Plan (Part D) - How do I sign up?

- Use the Medicare Plan Finder: www.medicare.gov/find-a-plan/questions/home.aspx
- Call 1-800-MEDICARE (1-800-633-4227)
- Call the plan you want.

To sign up for Part D, you must already be covered by Part A or Part B.

When do I sign up for Part D?

To sign up for Part D, you must already be covered by Part A or Part B.

If you're turning 65, here are time frames to sign up for Part D:

Initial enrollment period	The same as the initial enrollment period for Parts A & B
General enrollment period (for people who signed up for Medicare parts A & B during general enrollment)	April 1 - June 30 of each year
Open enrollment period	October 15– December 7 of each year

Medicare Advantage (Part C) - How do I sign up?

- Use the Medicare Plan Finder: www.medicare.gov/find-a-plan/questions/home.aspx
- Call 1-800-MEDICARE (1-800-633-4227)
- Call the plan you want.

When do I sign up for Medicare Advantage?

If you're turning 65, here are time frames to sign up for Medicare Advantage:

Initial enrollment period	The same as the initial enrollment period for Parts A & B
Open enrollment period	October 15 – December 7 of each year

Medigap – How do I sign up?

- Use the Medigap Plan Finder: www.medicare.gov/find-a-plan/questions/medigap-home.aspx
- Call 1-800-MEDICARE (1-800-633-4227)
- Call the plan you want.

In order to get Medigap, you must be covered by both Part A and Part B.



Employer-Sponsored Insurance - How do I get it?

- Ask your boss or your company's human resources office if you can get health insurance through your job.

Health Insurance Marketplace - How do I get it?

- Your Marketplace will be different depending on where you live, but residents of every state will have access to a Marketplace.
- You can start applying in October 2013 and can start using your new insurance on January 1, 2014.
- There will be a simple 3-page application. You will also be able to use this application to find out if you qualify for Medicaid or CHIP.
- Each Marketplace will also have **Patient Navigators** that can help you.
- Go to www.healthcare.gov/marketplace



TRICARE - How do I get it?

- Call 1-877-TRICARE (1-877-874-2273)
- Go to www.tricare.mil
- Talk to your commanding officer.

VA - How do I get it?

- Call 1-877-222-VETS (1-877-222-8387)
- Go to www.va.gov/healthbenefits/apply
- Go to your local VA.

IHS - How do I get it?

To get care from the IHS, you will have to prove that you are a registered member of a tribe.

To find your closest IHS center:

- Call 1-888-830-7280
- Go to www.ihs.gov/findhealthcare

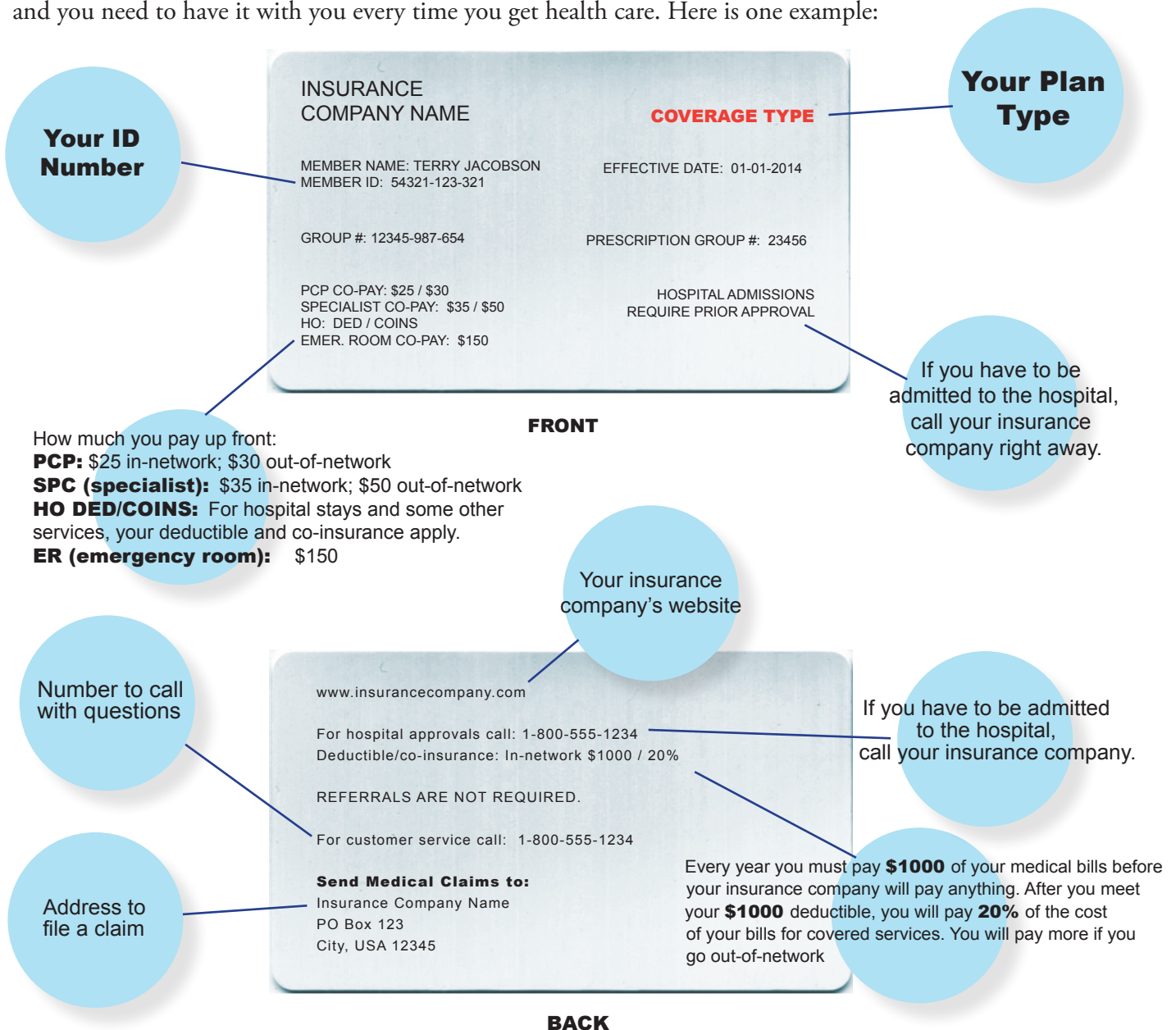


3 How Do I Use It?

In order to best use your plan, get to know it! The plan you buy has rules about where you can get health care services, which doctors and other health care providers you can see, and how much it will cost you.

What's on my card?

The most important tool for using your insurance is your insurance card. Not all insurance cards look the same, and you need to have it with you every time you get health care. Here is one example:





Here are some abbreviations that may be on your insurance card:

- SPC - specialist
- HO - hospital stay
- DED - deductible
- COINS - co-insurance



Here are some types of plans:

Medicare and Medicaid

Most doctors take Medicare, but not all doctors take Medicaid. Before you go, call the doctor's office and ask.

Health Maintenance Organization (HMO) / Prepaid Health Plan

- You use a network of doctors.
- You must see a doctor that is in your network.
- You must have a Primary Care Physician (PCP).
- Your PCP has to refer you to a specialist.
- In a prepaid health plan, the doctors work only for that plan, and most of the costs are covered up front.

Preferred Provider Organization (PPO)

- You use a network of doctors.
- You can go to doctors and hospitals that are in-network, or ones that are out-of-network.
- If you go to a doctor or hospital that is out-of-network, it will cost you more, and you may have to file your own claims.

Point-of-Service Plan (POS)

- You use a network of doctors.
- You must have a PCP, but you don't need a referral from your PCP to see a specialist.
- You can go to doctors and hospitals that are in-network, or ones that are out-of-network.
- If you go to a doctor or hospital that is out-of-network, it will cost you more, and you may have to file your own claims.

To get more information about your plan:

- Call the number on the back of your insurance card.
- Read your enrollment package or your Summary of Benefits and Coverage (SBC).
- Go to your insurance company's website.

Be sure you get a PCP. This person is your main contact for getting the care you need.



Where else can I get care?

Be sure to understand what your insurance company will cover and how much you will have to pay for health care at different places to see what they will cover.

Public Health Clinics: You can go to your local public health clinic for shots, birth control, HIV and STD testing, and mental health.

Retail Clinics: Some stores have clinics that can take care of common health problems, like strep throat and the flu. You can walk in or make an appointment, even at night or on the weekend. Check with your insurance company to see if they can help pay for your visit.

Urgent Care Centers: An urgent care center treats emergencies that are not life-threatening. Your insurance company may help pay these costs, but you should ask before you go.

Emergency Room: This is the best place to get care for life-threatening emergencies, but it will cost you more.

Your plan may not cover mental health services and visits to dentists, eye doctors, and therapists.
Before you go, call your insurance company to find out what is covered.



How do I use my insurance for prescriptions?

- After your doctor has prescribed a medicine for you, you need to know whether or not it's covered by your plan. Your plan has a list of medicines, called a drug formulary.
- Ask your doctor and your pharmacist if there is a generic of your prescription or a cheaper alternative in the same class of medicines. Doing this may cost you less money.
- You may have a separate insurance card for prescriptions. Be sure you understand the information on both sides of your prescription card, and have your card with you when get your prescription filled.



Summary of Benefits and Coverage (SBC)

All private insurance plans are required to give you a Summary of Benefits and Coverage (SBC). Understand what is in your SBC.

Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2014 – 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Spouse | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.\[insert\]](#) or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$500 person / \$1,000 family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes. \$300 for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers \$2,500 person / \$5,000 family For non-participating providers \$4,000 person / \$8,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

This is an example of what a SBC looks like.



What will it cost me?

To figure out your costs, here are some words you need to know:

Co-Insurance (cost-sharing): your share of the costs of a covered health service.

Co-Pay: a fixed amount you pay for a covered service when you get it.





Covered Services: health care that insurance companies help pay. This is specified in your health plan.

Deductible: the amount of money you need to pay each year before the insurance company will start paying. The costs that count as part of your deductible depend on the insurance plan you have.

You have to “meet” or pay your deductible every year before your insurance will pay for anything. For example, if your deductible is \$1,000, your insurance company will only start paying after you have spent \$1,000 out-of-pocket in medical bills. However, some visits (like shots, well check-ups, and cancer screenings) may be paid for by your plan (and free to you), even if you have not met your deductible. Services that are not covered by your plan do not count toward your deductible. Be sure you understand what services are covered and not covered by your plan.

Federal Poverty Level: a measure of income set by the U.S. government.

Formulary: a list of drugs covered by your insurance plan.

Network: a list of doctors and hospitals. In-network providers have contracts with an insurance company to offer less expensive rates for services. It will cost you more to get care out-of-network.

Out-of-pocket Maximum: the most you will have to pay for medical bills for services covered by your plan during the year.

Premium: the amount of money you pay (usually monthly) to your insurance company. You pay this even if you do not use any health care services. Usually, you pay a lower monthly premium if you have a higher deductible.



Every time you use health care services, there will be a charge.



What's an example of how the deductible and co-insurance work?

Terry was in a bad car wreck, broke several bones and had to have surgery. He has a PPO. Using only his **in-network** doctors and hospital, his medical bills were \$50,000. His **deductible** is \$3,000, and his **co-insurance** is 80%, and his out-of-pocket maximum is \$6,000. He hasn't paid for any medical care so far this year before the accident.



First, Terry has to pay his \$3,000 deductible. That means his insurance company will help him pay the \$47,000 that is left. Because his co-insurance is 80%, his insurance company will pay 80% of the \$47,000. Terry will have to pay the rest, which is \$9,400, but his out-of-pocket maximum is \$6,000. This means that he cannot pay more than \$6,000 total. In the end, Terry pays \$3,000 for his deductible and \$3,000 for his portion of co-insurance. He has now spent his out-of-pocket maximum of \$6,000 for this year, and the insurance company must pay for the rest.

Medical Costs In-Network PPO:

Ambulance ride to hospital	+\$500
Surgeon	+\$13,500
7 night hospital stay	+\$36,000

Total medical costs for car wreck \$50,000

Total Medical Costs	\$50,000
Terry pays his deductible	-\$3000
	\$47,000 due
Insurance company pays 80%	-\$37,600

**Total amount left that
Terry would have to pay \$9,400**

**Amount that Terry pays to
reach his out-of-pocket maximum -\$3,000**

Amount left for insurance to pay \$6,400

Summary:

Total amount Terry pays	\$6,000
Total amount insurance pays	\$44,000

Checklist for Costs

- ☐ Have I met my deductible?
- ☐ Is the provider or service in-network?
- ☐ Is the provider or service covered by my insurance plan?
- ☐ How much is my co-pay and/or co-insurance?
- ☐ Have I met my out-of-pocket maximum?



Health Insurance Marketplace – It's New!

Plans will be more or less expensive depending on what they cover and will be divided into four levels: platinum, gold, silver, and bronze. Levels differ on how much of health care costs your insurance plan pays and how much you pay. You choose which level makes the most sense for you based on how much you usually spend on your healthcare and how much you can afford.

Four types of plans:

Platinum

90% of costs paid by insurance company
high premiums
minimal out-of-pocket costs

Consider this if you think you will use a lot of health services (like hospital admissions, medical tests and treatments, doctor visits) during the year.

Gold

80% of costs paid by insurance company
moderate premiums
low out-of-pocket costs

Silver

70% of costs paid by insurance company
moderate premiums
medium out-of-pocket costs

Bronze

60% of costs paid by insurance company
low premiums
high out-of-pocket costs

Consider this if you do **not** think you will use a lot of health services (like hospital admissions, medical tests and treatments, doctor visits) during the year.

No matter what type of plan you buy, there will be a maximum on out-of-pocket costs.

Your out-of-pocket maximum depends on how much money you make.

- The maximum any individual will pay out-of-pocket in one year is about \$6,000.
- The maximum a family of 4 will pay out-of-pocket in one year is about \$11,000.



What if I can't afford a plan?

The government will help pay for your health insurance in the Marketplace in one of two ways.

1. Tax credits to help with monthly premiums

Money in the form of tax credits will be given to you in advance if your income falls between 100% and 400% of the Federal Poverty Level (FPL).

2. Subsidies to help with out-of-pocket costs

The state will help you with out-of-pocket costs if your income falls below 250% of the Federal Poverty Level (FPL).

For more information:

Every state's costs for the Marketplace insurance are different. If you use the Internet and want to see your state's costs, go to:

finder.healthcare.gov

You can find a calculator that can give you an idea of what you will pay based on your income, number of people in your family, and the area of the United States you live:

healthreform.kff.org/subsidycalculator.aspx

**Health Insurance Coverage
for All Americans!**

**Understand your choice,
how to get and use it,
and what it will cost you.**

Written by: Kara L. Jacobson, MPH; Clayton T. Marcinak;
Victor Y. Wu, MD, MPH; Ruth M. Parker, MD.

**A special thanks to the many patients who guided the
development of this brochure.**

This information is current as of May 1, 2013.

