



## Health Care Law & You

How to get the most out of your health care dollars



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The guide is not intended to provide legal and/or tax advice.

# Introduction

AmeriHealth New Jersey created this *Health Care Law & You* guide to help you understand how the new health care law, officially called the **Patient Protection and Affordable Care Act**, will affect you and your family. This law may change the way you buy your **health plan**, what health care benefits you receive, and how much you pay for your **health plan**.

The **Health Care Law & You** guide explains basic information that everyone needs to know about **health insurance** and the new health care law. It is full of information and tools that will help you get ready for the changes ahead as some key parts of the law are implemented. It includes:

- information on how **health insurance** works;
- questions you should ask yourself about your health care needs and finances;
- tips to help you choose a **health plan**;
- facts to consider when choosing a health insurance company;
- checklists to guide you through the selection process;
- a glossary that explains common health care terms.

You will notice that some of the words in the guide are in bold type. These are common health care terms that are described in the glossary on pages 22-25. The glossary contains easy-to-understand definitions to help you understand the **health care law**.

Keep this guide handy, and refer to it when you have health care questions in the months ahead.

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**This guide is helpful for people who:**

- **buy their own insurance;**
  - **have no insurance;**
  - **want to understand their current health insurance better;**
  - **want to know more about the health care law.**
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# Part I: 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 our 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 cost of treating a broken leg is about \$5,498. As you can imagine, the costs of more serious health problems can be crippling. Here are some examples of how much medical care can cost:

Health event	Care required	Cost without health insurance
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.

**Health insurance**, primarily through its coverage of preventive care services, helps you protect your health and well-being. It also limits your risk of paying for very expensive health care services. Here's how **health insurance** works for most people:

You choose a plan based on the cost of the plan and services it covers. For most plans, you will pay a **premium** to your **health insurance company**. This is a fixed amount you pay each month.

## Paying for Care

You also may pay each time you get care from a doctor or hospital, have a prescription filled, or get some type of medical care. These payments are frequently referred to as **cost-sharing**. How much you pay, and when you pay these fees, varies depending on your health plan. The **cost-sharing** fees you may pay include:

Cost-sharing fee	How it works
<b>Deductible</b>	The amount you pay each year before your <b>health plan</b> 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 health plan.
<b>Copayments</b>	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.
<b>Coinurance</b>	The percentage you pay for some covered services. If your <b>coinsurance</b> is 20 percent, your <b>health insurance company</b> will pay 80 percent of the cost of covered services; you will pay the remaining 20 percent. The amount you pay is typically not based on the full retail price of the service. It is based on a discounted rate negotiated by your insurance company with health care providers like doctors and hospitals.
<b>Out-of-pocket maximum</b>	No matter what, you will not pay more than the out-of-pocket maximum for each health plan. Any care for covered services you get after you meet your out-of-pocket maximum will be covered 100 percent. The estimated standard out-of-pocket max for 2014 is \$6,350 for individuals and \$12,700 for families.

## Types of Health Plans

The most common types of **health plans** are **Health Maintenance Organizations (HMOs)**, **Preferred Provider Organizations (PPO)**, and **Point of Service (POS)** plans. These types of health plans have several key differences.

### 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 **network**. **HMOs** usually have the lowest **premiums**.

### PPO

You don't have to choose a **PCP**, and you can go to doctors in or out of the **health plan's network**. You can see doctors, hospitals, and other health care providers of your choice, such as a heart doctor, but you will pay more if your doctor does not participate in your **health plan's network**. **PPOs** tend to have higher premiums than **HMOs**.

### Point of Service (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 in the network and outside the network. Members can also "self-refer" care, meaning that a member can receive benefits without a referral by a network or non-network provider. These benefits are paid at the Out of Network level. You will pay less when you see in-network doctors, hospitals, and other health care providers, and more when you see out-of-network providers.

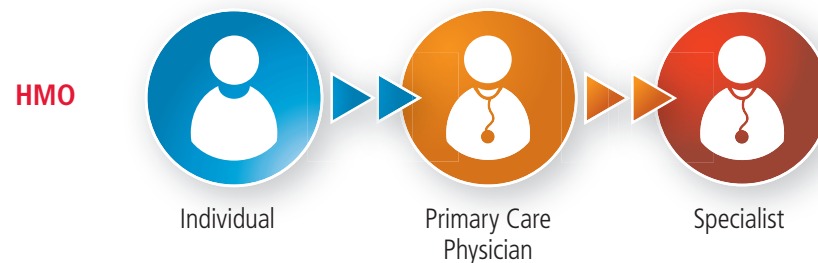
### Point of Service Plus

**POS Plus** plans allow members to receive benefits In-Network without a referral. Members enrolled in a POS Plus plan have In-Network and Out-of Network benefits. The highest level of benefits is paid In-Network, but a member can also go out of the network to receive benefits.

### EPO

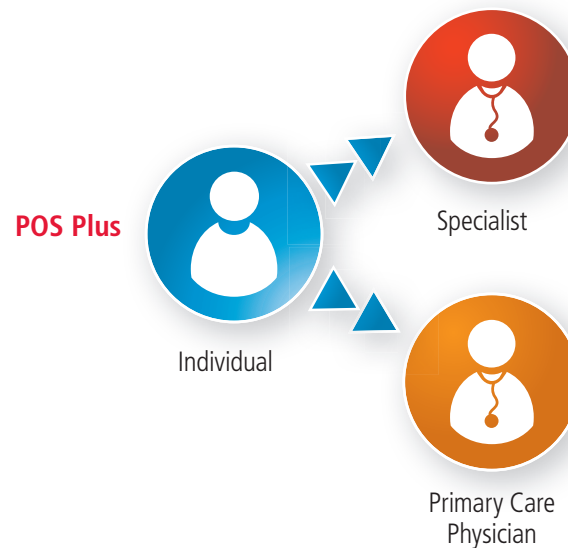
An **EPO** is an Exclusive Provider Organization. An **EPO** does not require referrals or the selection of a **PCP**. **EPO** members are free to receive benefits anywhere In-Network without a referral. An **EPO** plan only has In-Network benefits.

## What's the difference between an HMO and POS Plus?



### HMO Steps:

1. Make an appointment with a Primary Care Physician.
2. If you need to see a specialist, get a referral from PCP to an in-network Specialist that is selected by the PCP.



### POS Plus Steps

1. Make an appointment with either a PCP or a Specialist without needing to get a referral first. Can be an in-network doctor or an out-of-network doctor.

## Part II: Health Care Law is Here

If you're like many people, you wonder: What's all this fuss about the new health care law? How will it affect me and my family? Will it affect me in a positive way?

The good news is that this basic fact isn't changing: **health insurance** is one of the most important things you can do for your health. It pays for health care services that help you stay healthy. It also covers many of the services you need when you're sick or injured. If you work for a large company or organization that provides your health insurance today, most likely, you will continue to get your insurance through them in the future.

However, many things about **health insurance** are changing. Here are some of the changes that are taking place as part of the new **health care law**:

- People will be required to have health insurance.
- **Health plans** offered to people who purchase health insurance on their own and those that get benefits from an employer with 50 or fewer employees must include 10 core benefits, known as essential health benefits.
- Employees must work at least 30 hours per week to be considered full-time.
- Many single people and working families may get money from the government to help pay their health care coverage costs. This includes many people who the government does not help now.
- Many state **Medical Assistance** programs, also known as **Medicaid**, are expanding by offering **health plans** to more people who are uninsured.
- There will also be a new way to buy health insurance: the Health Insurance Marketplace.
- Rates for individual and small group plans (50 or fewer employees) will be based on who will be covered under the health plan, their age, where they live, and the health plan selected.

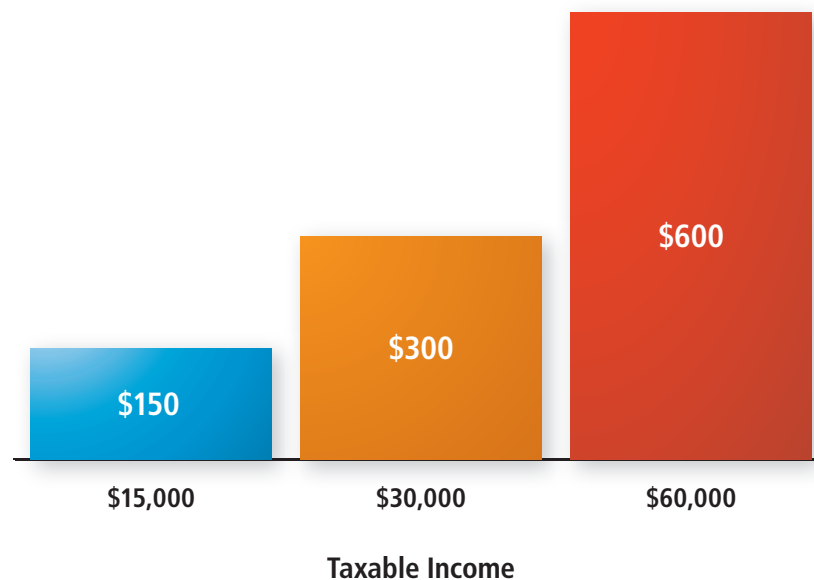
## Health Care Law & You

Having health insurance will be required as of January 1, 2014. Beginning in 2015, employers with 51 or more employees will be required to offer benefits to all full-time employees or face a fine. People that are not offered or do not qualify for an employer-sponsored benefit program will be required to purchase insurance on their own. Most people will pay a penalty to the government if they do not have a health plan. The penalty increases over the next few years, and you will be charged *the greater of these amounts*:

- **2014 penalty:** \$95 or 1% of your taxable income
- **2015 penalty:** \$325 or 2% of your taxable income
- **2016 penalty:** \$695 or 2.5% of your taxable income

Penalties are applied per person. You may be able to avoid the penalty if you are facing serious financial problems, have certain religious beliefs, or meet other rules. To get more information, visit [www.healthcare.gov](http://www.healthcare.gov).

## 2014 Sample Penalty for Individuals Without a Health Plan



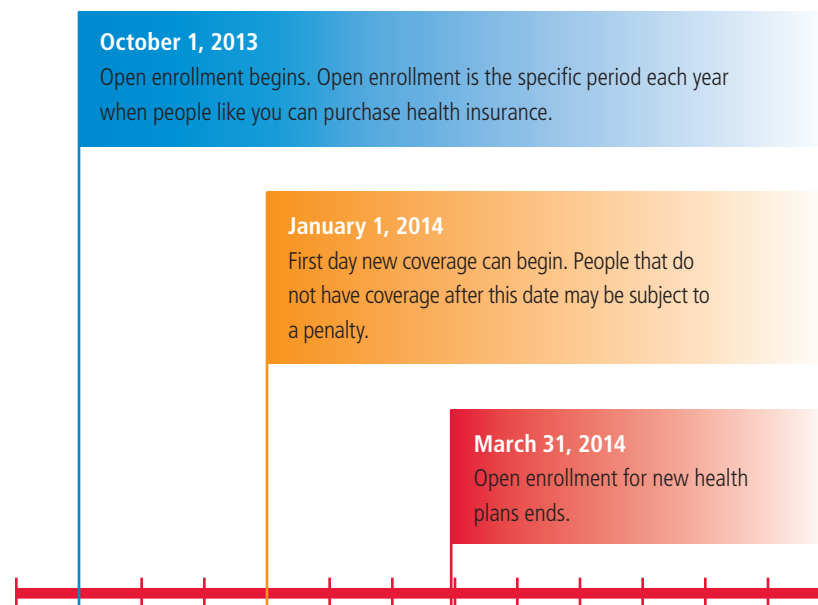
The **health care law** means more than having **health insurance** and getting many services. It has features that protect you and your family. The law provides the following protections:

- You can't be denied **health insurance** coverage.
- Your **health plan** can only be cancelled if you don't pay your bill or commit fraud.
- There are no annual or lifetime limits on the amount your health insurer will pay for **essential health benefits**.
- Your health insurer can't charge you more if you are sick.

### What's Ahead in 2014?

The new **health care law** requires that you have **health insurance** beginning January 1, 2014. On October 1, 2013, you will be able to visit online websites that can help you choose the right **health insurance** coverage for you and your family. For example, AmeriHealth New Jersey will have an easy-to-use website that will help you compare and buy your health plan.

### Health Care Law Timeline



If you experience a life event change, you will be able to apply for individual coverage after March 31, 2014. You will need to complete your application within 60 days of your life event.

Examples of life event changes are:







- given birth to a baby
- moved to a different state
- lose your health care coverage from your employer
- become eligible for different products due to changes in your income





## Part III: Major Changes in 2014

### What Health Benefits Your Plan Will Include

In 2014, all **health plans** offered to people who purchase their own health insurance and small businesses (2-50 employees) must include a core set of **essential health benefits**.

There are no annual lifetime limits on the amount your **health plan** spends on these core services for you and your family. **Essential health benefits** include these ten categories of services:

Essential Health Benefit	Example
 Preventive, wellness and disease management services	Physical, flu shot, gynecological exam, birth control
 Emergency care	Treatment for broken bones, heart attacks and more at a hospital emergency room
 Ambulatory services	Minor surgeries, blood tests, X-rays
 Hospitalization	Treatment at a hospital for a condition that requires you to stay overnight or multiple days
 Maternity and newborn services	Care through the course of a pregnancy, delivery of the baby and checkups after the baby is born
 Pediatric services, including dental and vision	Well visits, shots to prevent serious health conditions, teeth cleanings, braces, exams, glasses and contact lenses

Essential Health Benefit	Example
 Prescription drugs	High blood pressure medicine, insulin, antibiotics, birth control pills
 Laboratory services	Blood test
 Mental health and substance abuse services, including behavioral health treatment	Getting help to deal with conditions like depression, alcohol abuse, and drug abuse
 Rehabilitation and habilitation services	Physical therapy, speech therapy, occupational therapy

In addition, insurers will cover 100 percent of the cost of many **preventive services**, such as wellness visits, immunizations, screenings for cancer, and other diseases. That means you will not pay any **deductible**, **copayments**, or **coinsurance** for many preventative services that can help you stay healthy.

### Why are immunizations and screenings important?





**Immunizations can keep you and your children from getting common diseases. Health screenings and tests can help your doctor diagnose cancer, high blood pressure, and other serious diseases early, when they are easier and less expensive to treat. Preventive services may help you avoid health problems and may even save your life. If you stay healthy and treat health problems early, you may avoid costly medical services in the future.**



## New Levels of Coverage Available

With the new **health care law**, the federal government is creating four levels of coverage or **metallic tiers** for plans offered to small businesses (2-50 employees) and people that purchase their own insurance. Plans will be assigned one of these **metallic tiers** based on how much of the cost for health care services is covered by the health insurance company. These “metal” categories — bronze, silver, gold and platinum — will make it easier for you to compare health plans among **health insurance companies**. All products will cover essential health benefits like doctor visits, prescription drugs, X-rays, and hospital stays. The major differences will be in what you pay when you need these services and the monthly cost of the health plan.

### How the metal tiers compare on costs:

				
	Platinum	Gold	Silver	Bronze
Monthly Cost	\$\$\$\$	\$\$\$	\$\$	\$
Cost When You Get Care	\$	\$\$	\$\$\$	\$\$\$\$
Good Option If You...	plan to use a lot of health care services	want to save on monthly <b>premiums</b> while keeping your out-of-pocket costs low	need to balance your monthly <b>premium</b> with your out-of-pocket costs	don't plan to need a lot of health care services

As you can see, bronze health plans will have the lowest monthly costs but will likely have higher cost-sharing when you use services. Platinum health plans will cost you the most each month, but your costs each time you need care will probably be lower.

Health insurance companies like AmeriHealth New Jersey will have tools to help you determine which health plan will provide the lowest overall cost based on your needs. By answering a few questions about the health care you receive each year, you can get an estimate on your monthly **premiums** and cost-sharing charges for receiving care.

## Catastrophic Plans Will Also Be Available for Some

Under the new health care law, **catastrophic plans** will also be available to people under age 30 and those with an extreme financial hardship that qualify for an exemption.

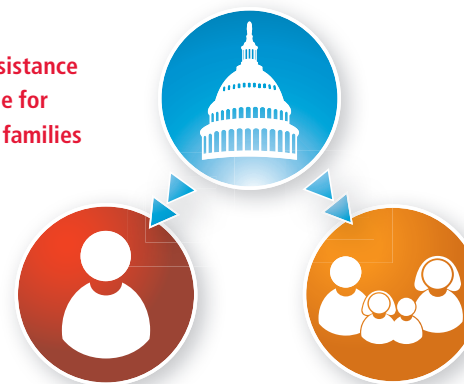
**Catastrophic plans** will include the ten essential health benefits described on pages 10 and 11 but will have a significantly higher deductible than the health plans in the platinum, gold, silver, and bronze metal tiers. It is estimated that individuals must meet a deductible of \$6,350 before they receive insurance benefits, while families will need to pay a deductible of \$12,700 before they receive benefits for Covered Services. The one exception is that people in a catastrophic plan will receive at least three office visits per year that are not subject to the deductible but may require the payment of a copay or coinsurance.

## Health Plans Are More Affordable for Many People

The government is committed to helping as many people as possible get health insurance. They will be providing **tax credits**, or **subsidies**, to help people who purchase their own insurance, including working families. The **tax credits** will be based on how much money you make each year and the number of people in your family. If you qualify, you may be able to get one of the following:

- free health insurance through **Medical Assistance**, also known as Medicaid;
- lower monthly **premium** costs plus a break on the **cost-sharing** you pay each time you need medical care;
- lower monthly **premium** costs.

Government assistance may be available for individuals and families





## Will you be able to get help?

To determine if you may be able to get financial help from the government, first locate the number of people in your family and your household income on the chart below. Then read the color-coded section on the next page that is most applicable to you. **If your family income exceeds these levels, you can skip this section of the Guide entirely.**

	Household Income		
Single	< \$15,282.00	\$ 15,282.00 - \$ 28,725.00	\$ 28,725.00 - \$ 45,960.00
Family of 2	< \$20,628.00	\$ 20,628.00 - \$ 38,775.00	\$ 38,775.00 - \$ 62,040.00
Family of 3	< \$25,975.00	\$ 25,975.00 - \$ 48,825.00	\$ 48,825.00 - \$ 78,120.00
Family of 4	< \$31,322.00	\$ 31,322.00 - \$ 58,875.00	\$ 58,875.00 - \$ 94,200.00
Family of 5	< \$36,668.00	\$ 36,668.00 - \$ 68,925.00	\$ 68,925.00 - \$ 110,280.00
Family of 6	< \$42,015.00	\$ 42,015.00 - \$ 78,975.00	\$ 78,975.00 - \$ 126,360.00
Family of 7	< \$47,361.00	\$ 47,361.00 - \$ 89,025.00	\$ 89,025.00 - \$ 142,440.00
Family of 8	< \$52,708.00	\$ 52,708.00 - \$ 99,075.00	\$ 99,075.00 - \$ 158,520.00

**Section 1:**  
**Medical Assistance**

**Section 2:**  
**Monthly Premiums**  
**and Cost-Sharing**

**Section 3:**  
**Monthly Premium**  
**Costs**

This chart is intended to give you an idea if you will be eligible for help from the government in paying your health insurance costs. For families of eight or more, add \$5,347. for each additional family member. Final eligibility determinations and the actual amount of your tax credit/subsidy will be determined by the federal government when open enrollment begins on October 1, 2013.

### Section 1. Medical Assistance

**Medical Assistance**, also called **Medicaid**, is a free public health insurance program offered by the Department of Public Welfare. Eligibility requirements for this program are complicated. There are requirements for income, number of family members in your household, and age. Certain disabilities will also be factored into eligibility decisions. For more information and to verify that you qualify for benefits, visit <http://www.state.nj.us/dobi/index.html>.

### Section 2. Monthly Premiums and Cost-Sharing

If you fall into this income range, you may receive assistance paying for your monthly health insurance premiums. This assistance will be in the form of **tax credits / subsidies**. The federal government will pay this amount directly to your health insurance company, which will lower your premium cost each month.

You may also be eligible to receive assistance with paying the fees you are charged, like **deductibles**, **copayments** and **coinsurance**, when you receive care. If you qualify for and want this assistance, the health care law requires that you select a health plan in the silver tier.

If you do not select a health plan from the silver tier, the federal government will still assist you with your share of the monthly insurance premium. However, you will not be able to get help in paying for deductibles, copayments, and coinsurance.

### Section 3. Monthly Premium Costs

If you fall into this income range, you may get a break on your monthly premiums. This assistance will be in the form of **tax credits / subsidies**. The government will help pay for your monthly health insurance costs. The money will be sent directly to your health insurance company each month so you will get the savings right away. You can apply **tax credits** for monthly premiums to any of the platinum, gold, silver, or bronze plans.

## Using Tax Credits

The good news is that a health insurance **tax credit / subsidy** is not like a regular **tax credit** that only gets applied on your tax return. It can be used right away to help lower your costs. If you qualify for a **tax credit**, you get to decide how it gets applied. You can decide to use all of your **tax credit** right away to lower your monthly costs or you can apply a portion of it to your monthly costs and use the rest as a credit on your taxes. You can also choose not to apply any of your **tax credits** right away and instead take the whole credit on your tax return. You have the control over how it is used. Here are some examples of how **tax credits** can lower costs for individuals and families.



### Individual

Joe, age 27  
Income: \$27,500  
Premiums: \$4,069  
Tax Credit: \$1,961  
Cost to Joe: \$2,108



### Family of Four

Jane, age 35, husband John, kids  
Katie & Jack  
Income: \$65,000  
Premium: \$13,324  
Tax Credit: \$7,574  
Cost to Jane: \$5,750

Source: Kaiser Family Foundation calculator

If you decide to use all or a portion of your **tax credits** right away, you have to report them on your annual federal tax return. You can contact the **Health Insurance Marketplace** (see Getting Reliable Help on page 19) to have your **tax credits** reviewed if your income changes during the year.

## Part IV: Make the Right Choice

### Annual Enrollment Starts in October

**Annual enrollment period:** You can purchase one of the new individual insurance plans beginning on October 1, 2013, and every day thereafter through March 31, 2014. During this six-month-long **enrollment** period, you can explore your options, decide which **health plan** is right for you and enroll in the plan of your choice. Your plan will take effect on January 1, 2014, or the next effective date, if you enroll after January 1.

There will be an **annual enrollment** period every year. This will be the specific period during which you will be able to renew your health plan, or change to another **health plan**.

### Getting Reliable Help

You don't have to figure out the ins-and-outs of the health care law on your own. **Health insurance companies** and the **Health Insurance Marketplace** offer free, easy, and confidential online tools to help you make the right choices about your **health insurance** needs. These tools help you consider your personal situation and find the **health plan** that offers the benefits you need at a price that best fits your budget.

Here's how they can help:

- **Your health insurance company's website.** Most insurers have easy-to-use websites where you can buy your **health plan**. You will get the support you need to choose the **health plan** that's best for you. Many of these tools will link to a federal website where you can verify your eligibility for health insurance, and find out if you can get **tax credits** to lower your costs.
- **The Health Insurance Marketplace.** This is a new way for you to see, compare and buy health insurance. The **Marketplace** will also link to a federal database to verify your eligibility and find out if you qualify for **tax credits**. You can then view apples-to-apples comparisons about the qualified **health plans** in your area that may be right for you.

You can log on to these sites from the comfort of your home or anywhere you can access the Internet. If you don't have access to a computer, you can:

- Get help over the phone. You can call the **Marketplace** toll-free. Many **health insurance companies** have toll-free numbers you can call to talk with experts who will answer your questions. They also can talk with you about your needs, and help you choose and buy a health plan over the phone. AmeriHealth New Jersey's toll free number is 1-888-879-5331.
- Work with **Marketplace navigators** or **health insurance** brokers. **Marketplace navigators** can give you unbiased information about the health plans that might be right for you. They can help you consider your options, and help you enroll in the plan of your choice. **Health insurance** brokers usually represent several health insurance companies and can help you select products from those companies.

## Get Ready to Choose a Health Plan

There are many things you want to think about before you buy a **health plan**. There's no one-size-fits-all when it comes to health insurance. Thinking about your needs, the things you prefer, how much you can afford, and what health care costs you might have will help you narrow your search for a **health plan**. Here's a list of some of the questions that you may want to ask yourself to get a better understanding of your needs:

- Is it important to you to have dental, vision, and wellness services?
- What services are covered beyond the **essential health benefits**?
- How much will I pay every month in **premiums**?
- How much will I pay for my **deductible, copayments** and **coinsurance**?
- Are the medications I use covered by the plan? How much will I have to pay for them?
- Can I see the same doctor I see now?
- Can I go to my local hospital?
- How much will I pay if I go outside the **network**?
- What services and programs does each plan offer to help me stay healthy?
- Does the plan cover services when I travel?

## Choosing a Health Insurance Company You Can Trust

There's a lot to think about as 2014 approaches. Do you qualify for a break on your health insurance costs? What health plan is right for you? How do you enroll? There's another important question to ask: How do you choose a **health insurance company** to manage your **health insurance** needs?

If you don't already have a **health insurance company** you trust, don't worry. This checklist will take the guesswork out of choosing the right company for you and your family:

- Does the insurance company have online shopping tools that will help you select a plan that meets your needs? Look for a company that offers easy-to-use tools that help you have a positive shopping experience.
- What do people you trust say about the company and its **networks** of doctors and hospitals? Ask them if they are satisfied with the company and its **networks** of doctors and hospitals? Did they provide good service?
- Do you prefer a company that is involved in the community and understands what people in your area need?
- Is experience important to you? How long has the company been in business?
- Does the company offer extra support if you have a chronic disease like diabetes, asthma, or heart disease? Some **health plans** have programs like counseling and support to help people with these conditions.
- What kind of programs and services does the company offer to help you stay healthy? Does the company offer classes and programs on nutrition, fitness, and other health topics? Does it offer incentives to help you stay healthy? Will they help you lose weight or quit smoking?

You can also visit the New Jersey Department of Banking and Insurance at <http://www.state.nj.us/dobi/index.html> to find more information about the health insurance companies you're considering.

## How to Get Ready for the Health Care Law

It's not too early to start preparing for **open enrollment**. Here are some things that you may want to consider so you are ready.

- Make sure you know how insurance works and what its most frequently-used terms mean (see the Glossary on pages 22-25).
- Think about what you need in a **health plan**. You want a 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.
- Make a list of issues that are important to you, so you can compare plans.
- Find out about the **networks** of doctors and hospitals for the health plans you're considering. This will tell you which doctors, hospitals, and other health care providers you can see at lower **in-network** rates.
- Ask about each health plan's lists of the prescription drugs it covers; these lists are often called a **formulary**. A **formulary** is a list of approved drugs covered by a **health plan**. Many **health plans** use tiered formularies. Your costs probably will be more for drugs in higher-numbered tiers. There usually will be lower-cost and higher-cost drugs for a specific condition you may have. Your lowest costs are typically for generic drugs.
- If you have a child who is covered through your health insurance and is living away from home, you will need to find out if your child can get **in-network** care where he or she lives. If in-network services are not available where your child lives, he or she may have to pay more for services from **out-of-network** doctors and hospitals, or come home for services.
- Evaluate the **health insurance companies** that offer the **health plans** you're considering.
- Try some online shopping tools to get an idea of how they can help you make your health care choices.

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### Ready to start now!

Some health insurance companies have a lot of information online to help you understand how the health care law will affect you. Visit the AmeriHealth New Jersey site at [amerihealthnj.com](http://amerihealthnj.com) or another insurance company's website to learn more!

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## Checklist

What you will need when you apply for health insurance:

### ☐ Household Income

Get a copy of your 2012 federal income tax return. The income you reported on this return is what you will provide as your household income to see if you are eligible for **Medical Assistance** or a **tax credit**.

### ☐ Social Security Number

You will need your social security number and the social security numbers of the members of your family that you want to put on your **health plan**.

### ☐ Health Care Needs

List the number of times in a year you visit a doctor or specialist, get prescriptions filled, and any planned surgeries or hospital stays. You will need this information to help calculate your total health care costs.

### ☐ Your budget

Set a budget of how much you can comfortably spend on your **health plan**. Make sure you include monthly **premiums** and **cost-sharing fees (deductible, copayments, and coinsurance)**.

When you have gathered this information, you'll be ready when **open enrollment** begins!

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### Need Help? Check Out These Resources

Federal government website: [healthcare.gov](http://healthcare.gov)

New Jersey Department of Banking and Insurance's website:  
<http://www.state.nj.us/dobi/index.html>

AmeriHealth New Jersey: [amerihealthnj.com](http://amerihealthnj.com) or 1-888-879-5331

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## Part V: Glossary of Common Health Care Terms

Here are simple definitions of some of the health insurance 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.

- **Catastrophic plan**

Benefit program available to people under age 30 or those with extreme financial hardship. Benefits are subject to an individual estimated deductible of \$6,350 or a family deductible of \$12,700. People in a catastrophic plan will be able to get three office visits per year that are not subject to the deductible but may require payment of a copay or coinsurance.

- **Coinsurance**

The percentage you pay for some covered services. If your coinsurance is 20 percent, your health insurance company will pay 80 percent of the cost of covered services, and you will pay the remaining 20 percent.

- **Copayment (Copay)**

The fee you pay when you see a doctor or get other services.

- **Cost-sharing**

The amount you pay for your health care costs beyond your premium. This includes your deductible, copayments, and coinsurance fees.

- **Deductible**

The amount you pay each year before you start to receive insurance benefits.

- **Essential health benefits**

A list of core benefits that all health plans must provide under the health care law. This includes many basic services, such as doctor visits and hospital stays. Benefits will also include preventative care, maternity care, and mental health services.

- **Formulary**

A list of approved drugs covered by a health plan. Many plans use tiered formularies. Your costs probably will vary for drugs in different tiers. There usually will be lower-cost and higher-cost drugs for a specific condition you may have. Your lowest costs are typically for generic drugs.

- **Habilitative services**

Therapies that help people learn skills and functions that are not developing normally. These services are an essential health benefit under the health care law. One habilitative service is speech therapy for children who are not learning to talk as they should based on their age.

- **Health care law**

A short way to refer to 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. This law is sometimes referred to as Obamacare.

- **Health insurance**

A type of insurance that helps pay for health care services. It helps you pay for expensive services when you are sick or injured.

- **Health insurance agent**

A person who represents one or more health insurance companies. An agent can help you select products from the companies they represent.

- **Health Insurance Marketplace**

A new online website where you can compare and buy health plans. Some states have their own Marketplace. Others let the federal government operate their Marketplace. At this time, New Jersey uses the federal Marketplace.

- **Health plan**

A health insurance product that offers a specific set of benefits for a certain cost.

- **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 a specialist in the HMO network, such as a cardiologist (heart doctor). Typically, only emergency services are covered if you go outside the health plan network.

- **Health savings account (HSA)**

A medical savings account for individuals with health plans that have high deductibles. You can contribute pre-tax dollars to an HSA. You can use these tax-free funds to pay for approved health costs.

- **Marketplace navigator**

A person who offers unbiased information and can help you understand your health care options and navigate the Health Insurance Marketplace website.

- **Medical Assistance/Medicaid**

Free public health insurance program administered by the Department of Public Welfare.

- **Metallic tiers**

Benefit levels the government is creating to make it easier to compare health plans. The metal tiers include platinum, gold, silver, and bronze. Health plans will be assigned to one of these tiers based on how much of the cost for health care services is covered by the health insurance company.

- **Network**

The doctors, hospitals, labs, and other health care providers who contract with a health insurance company to deliver services to members like you and your family. They usually charge the insurance company discounted rates for their services.

- **Out-of-network**

Doctors, hospitals, labs, and other health care providers who do not have a contract with a health insurance company. Members typically pay more for services from out-of-network providers. Some health plans may not cover services from these providers (e.g., HMO plans).

- **Out-of-pocket costs**

The amount you pay for your health care services. The health care law sets a limit on your out-of-pocket costs, called an out-of-pocket maximum. Once you pay this amount, your health plan will pay 100 percent of the additional covered services you receive.

- **Patient Protection and Affordable Care Act**

This is the official name of the new health care law. President Obama signed this bill into law in 2010. Key parts of the law go into effect in 2014.

- **Premium**

The fee you pay to your insurance company each month to pay your share of your health plan's costs. This is separate from the deductible, copayments, and coinsurance amounts you pay when you use your benefits to receive covered services.

- **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.

- **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. HMO plans require you to choose a PCP, who will refer you to a specialist when needed. PPOs do not require that you choose a primary care physician.

- **Point of Service plan (POS)**

A plan that combines features of an HMO and PPO. You must choose a PCP to oversee your care and obtain a referral to see a specialist. You also have the option of paying more to "self refer care" and to see providers outside the network.

- **POS Plus**

A POS Plus plan works the same as a POS, but the Plus means that no referral is required.

- **Rehabilitation services**

Therapies that help people restore lost skills after an injury, illness, or following surgery. These services are an essential health benefit under the health care law. People who have hip surgery may need rehabilitation services, such as physical therapy, to regain their ability to walk.

- **Tax credits / subsidies**

Subsidies that will lower the costs of health care for many people based on their income level. Some people may be eligible for health plans with \$0 or low-cost premiums. Others will be eligible for tax credits that help lower their monthly premiums and also give them a break on their out-of-pocket health care costs (a deductible, copayments, and coinsurance amounts).





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**[www.amerihealthnj.com](http://www.amerihealthnj.com)**

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