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Why the Affordable Care Act Matters for Women:

Health Insurance 101

Women are the health care decision makers in our country – they make approximately 80 percent of the health care decisions in their families. Women take the lead role in choosing health plans, scheduling doctors' appointments, and making sure their loved ones are getting the care they need. Women need the right tools and information to access affordable, quality care and make the best health care choices for their families and for themselves.

Many women have questions about health coverage and how to use their insurance to ensure that their families can access health care services. While every family will have unique health care needs, the following information can help women understand how health insurance works, access health care services, and make informed health care choices.

Health Insurance Basics

Health insurance can be confusing, particularly for individuals who are newly insured. Knowing a few basics about health insurance can help you access quality, affordable care.

Qualified Health Plans or QHPs

- Health plans offered through the health insurance marketplaces are "qualified health plans." Qualified health plans cover essential health care services like annual well-woman visits, contraception and family planning care, immunizations, and maternity care. To help make your care more affordable, qualified health plans also limit the amount of money you must pay out-of-pocket for health care services. **If you signed up for private health insurance through the health insurance marketplaces (HealthCare.gov or your state's marketplace website), you are enrolled in a qualified health plan.**

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Premium

▸ A premium is the monthly payment you send to your health insurance company to pay for your health insurance coverage.

Under the Affordable Care Act, health plans cannot apply a deductible to preventive services, such as mammograms or cervical cancer screenings.

Cost-Sharing

▸ In addition to paying a monthly premium, an insurance company often requires you to cover part of the cost of a health care service. Cost-sharing is the amount you pay for a health care service, such as visiting the doctor or filling a prescription. Cost-sharing takes the form of co-pays, co-insurance, and deductibles.

Co-Pay

▸ A co-pay is a fixed amount of money that you must pay when you access care. Ex: A $20 co-pay for a visit to a doctor.

Co-Insurance

▸ Co-insurance is the percentage of the cost of a health care service that you must pay. Ex: If a plan requires you to pay 20 percent co-insurance for a $400 doctor's visit, you will pay $80.

Deductible

▸ The amount of money that you must spend out-of-pocket on covered health care services before your plan begins to pay for your care.
(Under the Affordable Care Act (ACA),health plans cannot apply a deductible to preventive services, such as mammograms or cervical cancer screenings.)

In-Network

▸ Insurance companies contract with specific providers to accept their enrollees as covered patients. Providers who have contracted with your health plan are considered "in-network." The insurance companies are responsible for providing you with a list of in-network providers.

Out-of-Network

▸ Providers who do not have a contract with your health plan are likely to be considered "out-of-network." Unless it's an emergency, if you access care outside of your plan's network, you likely will pay more than if you had accessed the same care in-network.

Allowed Amount

▸ "Allowed amount" refers to the amount of money that your plan will pay for a health care service. If your provider charges more than your plan's allowed amount for a service, you may be required to pay the difference out-of-pocket.

Unless it's an emergency, if you access care outside of your plan's network, you likely will pay more than if you had accessed the same care in-network.

Out-of-Pocket

"Out-of-pocket" refers to the type of costs that insured consumers must pay– often through co-pays, deductibles, and co-insurance. **Under the ACA, qualified health plans have limits on out-of-pocket expenses. By 2015, the maximum out-of-pocket costs for all marketplace plans will be $6,350 for an individual plan and $12,700 for a family plan.**

Qualifying life events like getting married, having a baby, or losing employer-sponsored coverage allow you to enroll in private health plans during a special enrollment period.

Open Enrollment

"Open enrollment" is the time period within which you can enroll in a new health plan. Private health insurance plans only accept new customers during open enrollment periods. If you are looking to buy a private plan in the marketplace, the next open enrollment period is **November 15, 2014-February 15, 2015.** (Note: Medicaid and the Children's Health Insurance Program (CHIP), which are administered by the government, accept new enrollees year-round.)

Special Enrollment Period

A "special enrollment period" is an opportunity to enroll in a new health plan outside of the open enrollment period. An individual must qualify for a special enrollment period in order to enroll outside of the openenrollment period. **Qualifying life events** like getting married, having a baby, or losing employer-sponsored coverage allow you to enroll in private health plans during a special enrollment period.

If you think you might qualify for a special enrollmentperiod, visit **Healthcare.gov** or call the Call Center at 1-800-318-2596.

Frequently Asked Questions about Using Health Insurance

Now that I'm enrolled in a health plan, how do I access care?

To access care with your new health plan, you should start by finding an in-network primary care doctor. Your health plan'swebsite has a provider directory. Use this directory to search for a primary care doctor near you.

If you need to visit a specialist, check with your plan to see if there are any requirements you need to meet before you access specialty care.

If you need to visit a specialist, check with your plan to see if there are any requirements you need to meet before you access specialty care. For example, some plans will require you to get a referral from a primary care doctor before you visit a specialist, like a heart doctor. (Some plans will not cover your specialty care if you did not first get a referral from a primary care doctor.)

- Note: Women do **NOT** need a referral from a primary care doctor to visit an OB/GYN, even though an OB/GYN is a specialist.

Ninety-eight percent of health plans offer online tools to help consumers calculate their out-of-pocket costs.

What does my plan cover?

- Under the ACA, all qualified health plans must cover essential health benefits. If you signed up for a qualified health plan in the marketplace, your plan covers essential health care services, including **ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.**

- All qualified health plans cover key preventive services like birth control, cervical cancer screenings, mammograms and breastfeeding support **without cost-sharing.**

- For more detailed information about covered services and cost-sharing requirements, refer to your plan's benefit guide. Your plan's benefit guide is availableon your insurance company's website.

What if there's an emergency and I access care outside of my network?

- If you or a family member experience a medical emergency, you will not be charged more if you access care outside of your network. Your health insurance company may ask for documentation of the medical emergency.

I know health insurance doesn't cover all of my health care costs. How do I know how much the plan covers and how much I will need to cover out-of-pocket?

Cost-sharing requirements for specific health care services will vary. Refer to your plan's benefit guide to find out what you should expect to pay for a specific type of service.

- To estimate how much you should expect to spend out-of-pocket on the cost of your care, look at the "color" of your qualified health plan; bronze, silver, gold, or platinum. **The difference between plan colors is the amount of health care costs that the plan covers.** A bronze plan covers 60 percent of your health care costs, a silver plan covers 70 percent, a gold plan covers 80 percent, and platinum plan covers 90 percent. If you chose a bronze plan, you'll pay 40 percent of your health care costs through co-pays, co-insurance, and

deductibles. If you chose a silver plan, you'll pay 30 percent of your health care costs through co-pays, co-insurance and deductibles, and so on.

- No matter which level plan you have, your plan will cover key preventive services, like birth control, cervical cancer screenings, and mammograms, **without cost-sharing.**

Your plan's pharmacy benefit guide will list which prescription drugs are covered by your plan. Your plan's pharmacy benefit guide – often referred to as a "drug formulary" – is available on your insurance company's website.

- **Ninety-eight percent of health plans offer online tools to help consumers calculate their out-of-pocket costs.** To access these tools, you may need to go to your health plan's website and log-in to your account.

- If you are eligible for cost-sharing assistance, you will pay less out-of-pocket. For example, if you are eligible for cost-sharing assistance, the amount you must pay in co-pays or co-insurance will be reduced.

What is the cost-sharing requirement for a specific health care service?

- Cost-sharing requirements for specific health care services will vary. Refer to your plan's benefit guide to find out what you should expect to pay for a specific type of service. Your plan's benefit guide is available on your insurance company's website.

- As you discuss treatment options, you should not hesitate to ask your doctor about the cost of a test or procedure. You have the right to know how much your care will cost so that you can make informed health care decisions.

- Both individual and employer-sponsored health plans are generally requiring consumers to cover a larger percentage of their health care costs out-of-pocket. This makes it especially important to understand your cost-sharing responsibilities.

Cost-sharing requirements for prescription drugs vary, depending on the drug's "tier." For example, generic drugs are often categorized as Tier 1, whereas specialty drugs are often categorized as Tier 4.

What is cost-sharing assistance?

- Cost-sharing assistance reduces the amount of money you need to pay out-of-pocket when you go to the doctor or fill your prescription. Individuals and families with incomes up to 250% of the federal poverty line ($28,725 for an individual and $58,875 for a family of four) are eligible for cost-sharing assistance.

What if my insurance company denies a claim for my care?

▸ If your insurance company denies a claim for your care, you have the right to challenge the decision. Your insurance company is required to tell you why it denied the claim and how to appeal the decision.

Tier 1 drugs require the lowest cost-sharing and higher tier drugs require greater cost-sharing.

Which prescription drugs are covered?

▸ Your plan's pharmacy benefit guide will list which prescription drugs are covered by your plan. Your plan's pharmacy benefit guide – often referred to as a "drug formulary" – is available on your insurance company's website.

▸ If your doctor prescribes a drug that your health plan does not cover, you can apply for an exception. In order to be granted an exception or "waiver," your doctor will need to explain to your insurance company the reason he/she has prescribed the specific drug. If your insurance company denies your request for an exception or waiver, you can file an appeal.

▸ If your doctor prescribes a drug that does not have a generic version, your health plan likely covers the name-brand version, although the cost-sharing requirement may be higher.

How much will I have to pay out-of-pocket for a specific prescription drug?

▸ Cost-sharing requirements for prescription drugs vary, **depending on the drug's "tier."** For example, generic drugs are often categorized as Tier 1, whereas specialty drugs are often categorized as Tier 4. **Tier 1 drugs require the lowest cost-sharing and higher tier drugs require greater cost-sharing.**

▸ Refer to your plan's pharmacy benefit guide – often referred to as a "drug formulary" – for specific cost-sharing requirements. Your plan's benefit guide is available on your insurance company's website.

▸ You should not hesitate to ask your doctor about the cost of a prescription drug. **Ask your doctor if he/she is prescribing a generic drug and/or if a generic version of a drug is available.** Your doctor can explain the benefits or risks associated with taking a generic drug, rather than the name-brand version. You have the right to know how much your medication costs, so that you can make an informed health care decision.

How do I contact my insurance company?

▸ Contact information for health plans offered in the marketplaces is available **here.** Insurance companies offer many different health plans and the customer service contact information may be different for each plan.