



BlueCross BlueShield of Texas

Understanding Health Insurance

Your Guide to the
Affordable Care Act



Summary

Health insurance may seem like a luxury if you are on a tight budget. But protecting your health — and your family — is one of the most vital choices you can make. If you don't have coverage, you may pay a tax penalty.

You will also have to pay out of pocket for all health care costs like:



Emergency room visits

If you are seriously ill or injured, you may need to visit the emergency room. Health insurance can help you pay for expensive services like X-rays, tests and surgery. But if you don't have insurance, you may have to pay for everything on your own.



Prescription Drugs

Prescription drugs can be expensive. Many health insurance plans pay for part of the cost of prescription drugs, helping you to manage your medical spending.



Other medical services

Even if you are healthy, you may need medical services from time to time. But tests, screenings and treatment can be costly. If you have health insurance, you may only pay a percentage of the cost or a fixed amount for certain services. Insurance plans may even pay the entire bill for some routine exams — at no added cost to you.

Do you need health insurance?

As of Jan. 1, 2014, most of us have to have health care coverage. Coverage includes health insurance through an individual or employer plan, or a program like Medicaid or the Children's Health Insurance Program. Without it, you may face a tax penalty.

For 2014, the annual tax penalty for being uninsured is \$95 per adult and \$47.50 per child. That means either an annual tax penalty of \$95 for individuals and up to \$285 for families, or 1 percent of income above the **filing threshold**, whichever is more. The tax penalty goes up each year. Please consult your tax advisor for any tax questions.



Filing threshold

You have to make at least this amount of money to file federal income taxes. For individuals, it's \$10,150. For families, it's \$20,300. If you make less than that threshold, you won't owe a penalty.



Cindy earns \$19,000 a year.

Earnings	\$19,000
Filing Threshold	- 10,150
	= \$8,850 (income over filing threshold)
	1% of income over threshold = \$88.50 ($\$8,850 \times 1\% = \88.50)

She will pay either \$95 or 1% of her income above the \$10,150 filing threshold, whichever amount is more.

In this case, Cindy would pay a tax penalty of \$95 for not having coverage.



Lyle and Ginger earn \$50,000 a year and have three children under 18.

Earnings	\$50,000
Filing Threshold	- 20,300
	=\$29,700 (income over filing threshold)
	1% of income over threshold = \$297 ($\$29,700 \times 1\% = \297)

They will pay either \$285 or 1% of their income over the \$20,300 filing threshold, whichever amount is more.

In this case, the family would pay a tax penalty of \$297 for not having coverage.

What are your options?

1

You can buy coverage through Blue Cross and Blue Shield of Texas (BCBSTX) or an insurance agent. You can call your agent or contact BCBSTX at 888-731-0406.

2

You may also buy coverage through the Health Insurance Marketplace. In fact, you can apply for Marketplace coverage directly through BCBSTX, even if you qualify for federal assistance.

3

You or your family may also be able to sign up for a program like Medicaid or the Children's Health Insurance Program, or CHIP.

4

You may not have to pay a tax penalty if you are part of certain religious groups, an American Indian, have a financial hardship or otherwise qualify for an exception.

When can you enroll on the Marketplace?

Open enrollment for 2014 was Oct. 1, 2013, through March 31, 2014.

It has now ended for 2014. Open enrollment for 2015 plans will begin on Nov. 15, 2014, and conclude on Feb. 15, 2015.

However, there are some reasons you may also be able to get coverage outside of open enrollment, such as:

- You move to a new area that offers you different plans, or isn't covered by your HMO network.
- You get married.
- You have or adopt a child.
- You lose other health coverage due to job loss, a decrease in work hours, end of COBRA coverage or other reasons.*
- Your income changes, or some other event changes your income or household status.
- You become a U.S. citizen.
- You can prove that your health insurance company violated its contract with you.
- You are no longer covered on a family member's policy because you turned 26, you have legally separated from or divorced your spouse, or the policy holder has passed away.
- You are a member of an American Indian and Alaska Native tribe.

If any of these happen, you will have 60 days to go to the Marketplace to enroll in a health insurance plan or change plans.

* Please note that the following are not considered loss of coverage: voluntarily canceling your health insurance plan, having your plan canceled because you did not pay your premiums or because your plan did not meet the requirements set by the Affordable Care Act.

What if you can't afford insurance?

There are many health plans that can meet your needs and budget. You may be able to get a new kind of tax credit that can lower your premium.

When you look for a plan, you will be able to see your **premium**, **deductibles** and out-of-pocket costs before you make a decision to enroll.

You can apply either through BCBSTX or the Marketplace. When you apply, you will find out if you can get help paying for it.



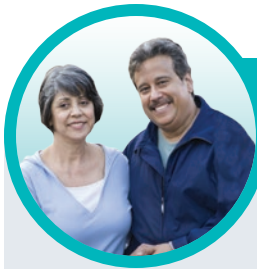
Premium

The ongoing amount that must be paid for your health insurance or plan every month.



Deductible

A fixed amount of expenses you have to pay when you receive care before you are reimbursed for a covered service.



The Morenos' household income is \$64,500.

Annual income	% paid toward premium
\$23,550 – 31,322	2%
\$31,322 – 35,525	3 – 4%
\$35,525 – 47,100	4 – 6.3%
\$47,100 – 58,875	6.3 – 8.05%
\$58,875 – 70,650	8.05 – 9.5%
\$70,650 – 94,200	9.5%

Insurance Plan

\$11,091 (annual premium)

8.63% (percent of annual income)

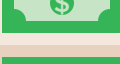
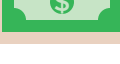
=\$5,566 (family's portion of premium)

\$11,091 (premium) – **\$5,566** (the family's portion of premium) = **\$5,525** (tax credit)

Those with a household income below \$23,550 may be eligible for health insurance from the Medicaid program.

What do the plans look like?

You can find plans in four levels — Bronze, Silver, Gold and Platinum.

Platinum	Monthly Cost	   	Good option if you plan to use a lot of health care services
	Cost When You Get Care		
Gold	Monthly Cost	  	Good option if you want to save on monthly premiums while keeping your out-of-pocket costs low
	Cost When You Get Care	 	
Silver	Monthly Cost	 	Good option if you need to balance your monthly premium with your out-of-pocket costs.
	Cost When You Get Care	  	
Bronze	Monthly Cost		Good option if you don't plan to need a lot of health care services
	Cost When You Get Care	   	

Catastrophic coverage provides the same type of coverage as the plans above, but has a lower premium and higher deductible than other health plans. This coverage is available on the Marketplace for people under age 30 and other people that qualify.

What should I ask when seeking a plan?

What provider network does the plan use?

Is your doctor in the plan's network? You might want to make a list of doctors, including specialists, physical therapists, pharmacies, hospitals and urgent care clinics you use and check to see if they are in the plan's network.

How often do you visit the doctor?

Do you only get sick a few times per year? Do you have a health condition that means frequent visits to the doctor or hospital?

How much can you spend?

Think about the monthly premium, but also keep in mind the deductible, copayments and other out-of-pocket costs to figure out what you could end up paying within a year, should you end up with unexpected medical bills.

Do you take prescription drugs?

Can you take a generic drug, or do you take name-brand drugs that may cost you more each month? Drug coverage may differ by plan.



Network

The doctors, hospitals and other health care providers that an insurance plan has contracted with to deliver health care services to the people it insures.

What do these new plans include?

Guaranteed Coverage

You will be able to get health insurance coverage, even with an existing health problem, when you apply for it during an open or special enrollment period.



Essential Health Benefits

Starting in 2014, most insurance plans will cover certain benefits considered essential to good health, such as:

- Emergency services
- Prescription drugs
- Hospitalization
- Maternity and newborn care
- Rehabilitative services and devices
- Ambulatory services
- Laboratory services
- Mental health/substance abuse
- Preventive/wellness services and chronic disease management
- Pediatric services



Preventive Services

Insurance plans cover many services considered preventive at no added cost to you. This means you may not have to pay a **copayment**, **coinsurance** or deductible for services such as:

- Annual exams and well-child visits
- Recommended vaccines and flu shots
- Cancer screenings such as mammograms, cervical and colorectal exams
- Obesity screening and counseling
- Alcohol abuse and tobacco use screenings, and help to stop
- Screenings for blood pressure, high cholesterol, diabetes and depression

Preventive services for women, such as:

- Well woman visits
- Pap smears
- Osteoporosis screenings
- Testing for HPV and HIV
- Counseling and screening for intimate partner violence
- Testing and counseling for STDs
- FDA-approved contraception methods and counseling
- Breastfeeding support, supplies and counseling



Copayment

A fixed dollar amount you are required to pay for a covered service at the time you get care.



Coinsurance

Your share of the costs of a covered health care service — usually a percentage of an eligible expense.

Health Plan and Provider Networks

Health plans use select groups of doctors, hospitals and other health care professionals who work together to provide a full range of covered health care networks. Some provider networks have fewer doctors and hospitals than others. Plans with smaller networks may have lower monthly premiums than plans with larger networks.

To keep costs low when using your plan, you'll want to make sure you stay “**in network**,” which means using the doctors and other health care providers that are in your plan's network. If you visit a doctor outside of your network, you may have to pay more for your care. In some cases, you may have to pay the full cost.

You can check the BCBSTX Provider Finder® online to see what doctors are in network for each plan you are considering before you buy coverage. Provider Finder is also the place to go to check for doctors or any specialists you need to see after you have coverage.

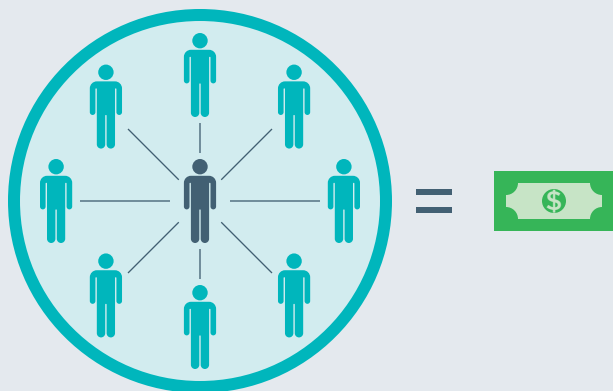


In network

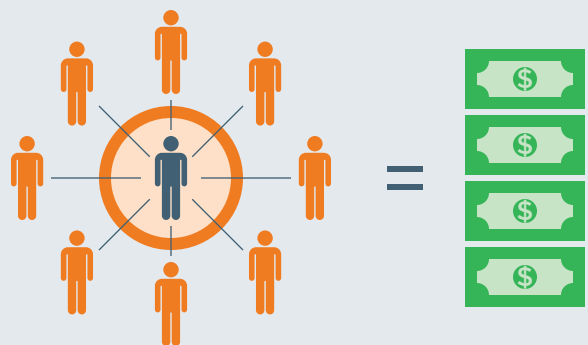
Covered services provided or ordered by your primary care physician (PCP) or another provider who is in your plan's network.

Choosing providers that are out of network could mean higher out-of-pocket costs for you.

In network



Out of network



Examples



Larry is 32 years old

- Has no chronic health problems
- Visits the doctor once a year for a physical
- Wants a low monthly premium
- Does not take prescription drugs

Larry may want to buy a **Bronze HMO plan**. A Bronze HMO plan may have a lower monthly premium and offers predictable copayments and a primary care physician to coordinate health care and provide referrals should he need to see a specialist. Larry may need a referral for a specialist or he could end up paying the entire cost for the visit. Also, if he is referred to a specialist, he needs to make sure the specialist is in his plan's network.



Mary is 47 years old

- Has diabetes
- Takes four prescription drugs (two are brand name and two are generics)
- Wants to make sure that her out-of-pocket costs are low
- Earns \$28,000, which means she should get a federal premium tax credit and cost-sharing assistance

Mary may want to pick a **Silver PPO plan** because she wants to go directly to the specialists she sees for her diabetes. By buying a Silver plan, she can also get cost-sharing assistance, which will help lower her out-of-pocket costs. She will want to compare the different Silver plans and make sure that the specialists she wants to see are in the provider network of the plan she chooses. To maximize her benefits, it is important that she only sees network providers.



Sarah and David have two children, Sam, 4, and Amanda, 7

- Check-up visits are important
- Sam has asthma, but no one else has major health issues
- They may have a third child soon

Sarah and David may want to pick a **Gold HMO plan**. While both HMO and PPO plans include preventive services like well-child/well-woman visits and maternity coverage, with two children, they may want a plan that has predictable copays. They will want to make sure the providers they want to use are in that plan's network and realize that they will have to get a referral from a primary care physician to see specialists for things like Sam's asthma.

What is the out-of-pocket maximum?

The out-of-pocket maximum, also called OOPM, is the **most** you have to pay **out of your own pocket** for expenses under your insurance plan during the year.

- Insurance plans may require you to pay for some expenses out of your own pocket when you need care
- The OOPM limits how much you can be charged for these expenses — protecting you in case of serious and expensive medical problems
- The government can change this each year. For 2015, it will be \$6,600 for individuals and \$13,200 for families.
- If you go out of your network, those expenses may not count toward your OOPM, so you could have to pay more.

Here's how it works:



Joe's plan has a \$6,350 out-of-pocket maximum



is the most Joe will pay this year out of **his own pocket** for medical expenses

Joe only pays for the medical care he uses.



If he's healthy, he may only pay for a few doctor visits and prescriptions.



But if he has an accident or major illness, that accident or illness could mean costly hospital bills. However, because Joe has health insurance and stays in network, he won't have to pay more than \$6,350 for covered expenses, **even if his care costs more.**

When you're ready, visit bcbstx.com

- Make a list of questions you have before choosing a health plan.
- Gather basic information about your household income.
- Decide how much coverage you need and set your budget.
- Sign up online at bcbstx.com, call us at **888-731-0406**, or visit your local insurance agent.

Also, if you are applying for insurance on the Marketplace, you may want to have this information handy:



Proof of U.S. citizenship or legal residency

Social Security Numbers or proof of legal residency for all family members



Current health insurance

Policy numbers for any current health insurance and information about available job-related health insurance



State residency

Driver's license, housing lease or utility bill



Immigration status/legal residency

Immigration document status numbers



Income for all family members

W-2 forms or pay stubs, unemployment/disability, Social Security/pension/retirement income, or a copy of your last tax return



Method of payment

How will you pay for an insurance plan? Personal check, cash or credit card?

So, what's next?

If you've decided to buy a health care plan, great! We've answered a lot of questions for new members. Here are a few that might help you once you select a plan.



How do I pay for my plan?

You can pay your premium through automatic recurring payments, personal check over the phone, online, by mail or by credit or debit card. For more details on how to pay, visit bcbstx.com/payment-options.



When do I get my insurance card?

You will get your insurance card through the mail after your application is approved. Your card will have your member and group number, information on your plan, copays and contact numbers to use if you need help. Keep it on hand at all times, because you never know when you might need it. In case of an accident, your card will provide emergency responders with important details.



What should I do before I go to the doctor?

Be sure to check that your doctor, provider or hospital is in your plan's network. If you go to a provider who is not in your plan's network, it will cost you more (unless it is an emergency). To check to see if your doctor is in network or if you want to find a new one, use our online Provider Finder.



How can I find a primary care physician?

You can use the Provider Finder by visiting bcbstx.com and clicking on Find a Doctor. The Provider Finder is designed to give you a list of doctors, hospitals and other health care professionals in the BCBSTX contracting provider networks. The Provider Finder helps you search for providers by name, location, plan network and specialty. You can also see what languages they speak and other useful information, as well as print maps and driving directions to providers.



What if my doctor isn't in network?

Part of the reason we're able to keep health care costs lower is because we work with doctors and hospitals within a specific network. Your out-of-pocket costs will be lower if you use a network provider. You can review the plans you are considering to see how they cover out-of-network services. Always check to make sure that your doctor or provider is in the plan's network.

The information provided in this document is based on current information, should not be considered comprehensive and should not be relied upon for benefit decisions. It should not be considered tax or legal advice.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
726779.0814