Choosing health insurance is one of the most important choices you can make to help protect your family’s health and well-being. We know health insurance can be confusing, so we’ve designed this guide to help explain the basics of health insurance and answer some common questions people have about health insurance.

Learn more at PAHealthOptions.com
THINGS TO CONSIDER WHEN SHOPPING FOR A HEALTH INSURANCE PLAN.
Everyone’s needs are different, and there may be several factors to consider in your choice. Five important questions to ask yourself:

- What do I need?
- What can I afford?
- What is included in the plan?
- How does the plan work?
- Does the network of healthcare providers meet my needs?

WHAT IS HEALTH INSURANCE?
Health insurance helps cover the cost of medical care, such as doctor visits, medical tests, surgeries, vaccinations and prescription drugs. Medical care can be very expensive and without health insurance, it is difficult to afford something as simple as a routine visit to the doctor, or medications for chronic conditions.

Health insurance is important even if you are healthy – medical bills for a serious accident or injury can accumulate quickly and drain your financial resources.

Health insurance plans often do not include vision and dental insurance, but separate plans are available to help cover those costs.

HOW CAN I GET HEALTH INSURANCE?
There are many different ways to obtain health insurance. Here are some of the most common ways:

Through your employer: Many employers make health insurance available to employees. Frequently, an employer will share the cost of the insurance premium with the employee. This is often the most affordable way to obtain health insurance, and is commonly referred to as “group” insurance coverage.

Through groups associated with employment: You may be able to obtain health insurance through a trade union or collective bargaining unit.

Through established membership associations: If you are a member of a chamber of commerce, trade association or similar organization, you may be able to obtain coverage through an association-sponsored plan. This could be a good option if you are self-employed or a small business owner.

On your own: If you are self-employed or do not have access to employer-sponsored health insurance, you can purchase insurance directly from an insurance company, online or through a licensed insurance agent. Typically, this is referred to as “individual” insurance.

Through the state or federal government: Children’s Health Insurance Program, Medical Assistance, Medicare and PA Fair Care are the primary government plans available in Pennsylvania.
CHIP: The Children’s Health Insurance Program provides coverage to uninsured children up to age 19 who are not eligible for Medical Assistance. No family makes too much money for CHIP. Most kids receive CHIP free, while others pay a low cost. Benefits include medical, prescriptions, dental, eye care and much more. (www.chipcoverspakids.com)

MA (MEDICAL ASSISTANCE): Also known as Medicaid, MA is a joint state and federal program that provides healthcare coverage to children and adults in low-income families who don’t have family health insurance, as well as the elderly and disabled.

MEDICARE: A federal program that provides healthcare coverage for all eligible individuals age 65 or older, or individuals under age 65 with a disability, regardless of income or assets.

PA FAIR CARE: PA Fair Care is Pennsylvania’s health plan for uninsured adults with pre-existing conditions. This is a temporary plan that offers transitional insurance coverage until federal healthcare reform comes to fruition in January 2014. The monthly premium is $283, plus co-pays and a $1,000 annual deductible. (www.pafaircare.com)

TRICARE: This program provides medical insurance for members of the armed services, retirees and their families. (www.tricare.mil)

VETERANS ADMINISTRATION: Patient care and health benefits for veterans and their dependents. (www.va.gov/healthbenefits)

Learn more at PAHealthOptions.com
TRADITIONAL INDEMNITY PLANS
An indemnity plan offers the most freedom in making healthcare choices. You:

- Do not have to choose a primary care physician.
- Can choose to see any licensed physician.
- Do not need a referral to see a specialist.

Indemnity plans are not very common. They typically cost more and require an individual to pay for services up front, and at the time of your appointment, before submitting to the insurance company for reimbursement.

HEALTH PLANS WITH PROVIDER NETWORKS
The most common types of health insurance plans are those that provide coverage of healthcare services through a network of participating providers.

HMO (Health Maintenance Organization)
An HMO provides coverage through a network of hospitals, doctors and other healthcare providers. The HMO will typically only cover care that is provided from an in-network provider. You will:

- Need to choose a PCP (primary care provider).
- Need a referral from your PCP (primary care provider) to see most specialists or for testing.
- Most likely have to pay out-of-pocket if you see a physician or undergo tests outside of the HMO’s network.

HMOs typically have lower premiums and co-pays and may not require you to meet a deductible. You do have to use providers within the network.

PPO (Preferred Provider Organization)
A PPO is a network of preferred providers, such as hospitals and doctors. You:

- Do not have to choose a primary care provider.
- Can see any physician within the network.
- Do not need a referral to see a specialist.
- Will pay more if you use a physician or facility that is not in the preferred network.

PPOs offer you more freedom of choice among providers and facilities and a portion of out-of-network claims is likely to be covered. You may have to meet a deductible before the insurance company begins to pay your claims.

CDHP (Consumer Directed Health Plans)
Used with a PPO product, this benefit design puts you in the driver’s seat. CDHPs combine a high-deductible health plan with a health savings account.
HDHP (High-Deductible Health Plan)
A health insurance plan that usually has lower monthly premiums and a higher deductible. (Your monthly payments are lower, but you pay more out-of-pocket before your coverage kicks in.) You might choose this type of health insurance plan if you want to control monthly costs but still be covered for emergencies.

HSA (Health Savings Account)
Usually used with a high-deductible health plan, this is a tax-free account you open to save money for qualified medical expenses. Contributions to an account may be made by an individual, an employer, a family member, another third party or any combination of these. Any money not used for expenses may be rolled over to use the next year.

POS (Point of Service)
A POS plan combines features of both the HMO and the PPO. You:
• Will need to choose a primary care provider.
• Do not need a referral to see a specialist.
• Can see physicians outside of the network, but will pay more out-of-pocket costs.

A POS plan usually covers preventive care. You may not have to meet a deductible and your primary care provider is the only one who must be in the POS network.

Learn more at PAHealthOptions.com
# Quick Reference Comparison of Health Plans

<table>
<thead>
<tr>
<th>TYPE OF PLAN</th>
<th>DESCRIPTION</th>
<th>CHOOSE A PRIMARY CARE PROVIDER?</th>
<th>NEED REFERRAL TO SEE SPECIALIST?</th>
<th>OUT-OF-POCKET COSTS IF USING OUT-OF-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDEMNITY PLAN</td>
<td>Offers the most freedom in healthcare choices; a more expensive, less common option</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>HMO</td>
<td>Provides coverage through a network of hospitals, doctors and other healthcare providers</td>
<td>Yes</td>
<td>Yes. Except for OB/GYN</td>
<td>Usually</td>
</tr>
<tr>
<td>PPO</td>
<td>A network of preferred providers, such as hospitals and doctors</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>POS</td>
<td>Combines features of both the HMO and PPO</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

## IMPORTANT PARTS OF THE PLAN TO REVIEW

Once you have the plans to compare, it may seem like you need a map or GPS to navigate through each plan’s paperwork! Here are some key pieces of information to review.

- **Doctor Participation**: One of the first things to check is if your physician participates in the plan. It is best to call your physician’s office directly to get the most up-to-date information.

- **Coverage**: Does the plan provide comprehensive coverage – coverage for routine care and catastrophic illness (often called “major medical”) – or only major medical coverage? Does the plan include coverage for prescription drugs?

- **Premium**: How much will the insurance cost you? This could be a monthly premium or a weekly/bi-weekly amount taken out of your paycheck.

- **Co-pays**: How much will you be responsible to pay when you go to the doctor? There are often different co-pays for primary care providers, specialists and emergency room visits.

- **Deductible**: This is the amount you will have to pay each year toward your medical expenses before health insurance begins paying claims. You may have an option to choose a higher deductible to pay a lower premium.

- **Preauthorization**: Does the health insurance company need to approve care or treatment before you receive it?

- **Pre-existing Condition**: Does the health plan cover your pre-existing condition or does the plan include an exclusion or waiting period for coverage of a health problem that you had before applying?

- **Exclusions**: The plan should identify what is not covered by the plan, if anything. Some exclusions could include:
  - Vision and dental coverage
  - Services that are not preauthorized
  - Experimental procedures
  - Services covered by another insurance policy
  - Pre-existing conditions

- **Limits of Coverage**: Some plans place a maximum dollar limit on how much they will pay for a certain service or within a period of time.
IF YOU HAVE QUESTIONS
There may be something in the plan information that you don’t understand, or maybe you’re not sure how it would impact your family’s needs. Don’t hesitate to ask questions and find the answers! Getting answers is an important part of choosing the right plan for you.

- If you’re getting coverage through your employer or groups associated with employment: Check with your employer’s human resources office or the individual who manages benefits. If you are not sure who that would be, ask your supervisor for help or call the customer service number on the back of your insurance card.
- If you’re getting coverage on your own: Call the customer service department of the insurance company or agent offering the plan or call the customer service number on the back of your insurance card.
- If you’re getting coverage through the state or federal government: You should find a phone number to call on the plan’s paperwork or website or call the customer service number on the back of your insurance card.

CONSUMER ALERT
Health insurance has become a hot topic and not everything calling itself “health insurance” is legitimate. Before you buy, make sure you know that you are purchasing coverage from a licensed insurance company.

Contact the Pennsylvania Insurance Department to verify that a company or agent is licensed or review a company’s complaint history. You can learn more about the financial health of the insurance company by checking with an independent financial rating service such as A.M. Best, Moody’s or Standard & Poor’s.

TEN THINGS TO ASK BEFORE ENROLLING IN A HEALTH INSURANCE PLAN
Because medical benefits, costs and types of plans vary widely, you need to examine your choices carefully. Remember, if a health plan sounds too good to be true, it maybe is. Here are 10 important questions to ask when you’re shopping for a health insurance plan:

1. Is the insurance company or agent selling the plan licensed by the Pennsylvania Insurance Department?
2. Is the company that offers the plan financially sound? Visit A.M. Best, Moody’s, Standard & Poor’s, or other independent financial rating services to find out.
3. Will you be covered for care in an emergency situation or when you’re out of town?
4. Is it a discount health plan or an actual health insurance plan?
5. How much coverage will you receive?
6. What are the real costs of the plan? Don’t be fooled by one or two low costs – take into account premiums, co-pays, deductible, coinsurance and other out-of-pocket expenses.
7. Are the doctors, hospitals, laboratories and other medical providers you use included in the network? (If you want to use a doctor outside the network, will the plan permit it and, if so, at what cost?)
8. Do you have to choose a primary care physician?
9. Do you need to get a referral before you see a specialist?
10. Are the prescription medicines that you use covered by the plan?

Learn more at PAHealthOptions.com
Getting insurance through a plan offered by your employer is often the most affordable option. Keep these things in mind when considering a plan offered by your employer.

OPEN ENROLLMENT
This is a period of time when you can compare the different insurance plans offered by your employer and make changes that do not qualify as special enrollment opportunities. During open enrollment, which generally happens once a year, employees have the opportunity to enroll in benefits for the first time, change their current plans or coverage amounts, or to drop coverage completely. These types of decisions can have a fairly significant financial impact so it’s important to pay attention to open enrollment periods and then weigh your options carefully.

SPECIAL ENROLLMENT
A special enrollment opportunity is a time outside of the open enrollment period when you may be eligible to enroll in a health insurance plan offered by your employer. Special enrollment is usually triggered by a major life event, such as:

- Starting a new job.
- Marriage (adding a spouse to your policy).
- Birth or adoption of a child.
- Losing health insurance provided by a spouse’s employer.
- Divorce.

Check with your human resources office to see if you or a family member are eligible for special enrollment. Special enrollment is not automatic – there are certain requirements that must be met, such as:

- Notifying your employer of the major life event within a specified amount of time (usually 30 or 60 days)
- If the plan is open to spouses, domestic partners or other dependents
- If the dependent has other options for health insurance

COVERAGE FOR YOUNG ADULTS
Under federal law, health plans offering dependent coverage must extend coverage to your young adult children up to the age of 26, even if the young adult is:

- Married
- Living on their own
- Attending school
- Not financially dependent on the parent
- Eligible to enroll in their employer’s group plan *

* Until 2014, “grandfathered” group plans do not have to offer dependent coverage up to age 26 if a young adult is eligible for group coverage outside their parent’s plan. Check with your plan administrator to see if this applies to you.
Under Pennsylvania law, young adults (up to age 30) may be eligible to remain covered by their parents’ health insurance. Pennsylvania employers make the decision whether or not to offer this extended coverage. If the Pennsylvania employer chooses to offer this opportunity, eligible young adults must:

- Be unmarried.
- Have no dependents.
- Be residents of Pennsylvania or enrolled as a full-time student at an institution of higher education.
- Not have private insurance or be enrolled in, or eligible for, government benefits.

To determine the coverage available for your children, please contact your employer’s human resources office.

IF YOU LOSE YOUR JOB
Losing a job is a life-changing experience. If your health insurance plan was offered by your employer, there are steps you need to take if you want to continue the coverage. COBRA may be your best option if you’re out of work, especially if you have a pre-existing condition. If you have a pre-existing condition and your coverage lapses, you may have trouble getting coverage in the future. But as long as you continue coverage through COBRA, you are protected.

COBRA CONTINUATION HEALTH COVERAGE
COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law that allows eligible individuals who lose health benefits through an employer to continue receiving those benefits for a certain period of time (usually 12 or 18 months). COBRA coverage goes into effect under certain circumstances, called “qualifying events,” such as if the covered employee:

- Loses or leaves a job.
- Experiences a reduction in hours.
- Becomes eligible for Medicare.
- Dies and had dependents (spouse and/or children) who were covered.

Fast Facts about COBRA
- It applies to former employees of companies that have 20 or more employees on 50 percent of its business days, and state and local governments.
- Eligible individuals will have to pay 100 percent of the premium plus any additional administrative fees.
- Eligible individuals are typically eligible for COBRA for up to 18 months. The timeframe can be extended in certain circumstances.
- To be eligible for COBRA, an individual has to have been enrolled in the plan prior to the “qualifying event.”

For more information on whether or not you are eligible for COBRA, please contact the employer’s human resources office or learn more at http://www.dol.gov/ebsa/pdf/cobraemployee.pdf.

PA MINI-COBRA CONTINUATION HEALTH COVERAGE
In Pennsylvania, PA Mini-COBRA is the law giving eligible employees of businesses with 2 - 19 employees the right to purchase continuation health insurance after leaving employment or another “qualifying event.” PA Mini-COBRA is modeled after COBRA.

Fast Facts about PA Mini-COBRA
- It applies to eligible individuals who worked for a smaller business in Pennsylvania with 2 - 19 employees.
- Eligible individuals will have to pay 100 percent of the premium plus any additional administrative fees.
- Eligible individuals are typically eligible for PA Mini-COBRA for up to nine months.
- Individuals are not eligible who are covered or who are eligible to be covered by Medicare or other employer-based group health insurance as an eligible dependent.

For more information about PA Mini-COBRA, contact the employer’s human resources office or visit the Pennsylvania Insurance Department online at PaHealthOptions.com.
CONVERTING YOUR POLICY

If your COBRA or PA Mini-COBRA coverage is coming to an end, you have the option to convert your policy from a group policy to an individual policy. There are two possible ways to do this.

PA Individual Conversion Policy

You can convert your group policy into an individual policy if your current group policy contains a conversion right. You can find this out by contacting your employer, the insurance company or by reviewing your member handbook. If the policy contains a conversion right, you should receive an application and information about your conversion options from the insurance company. If you do not receive this information, contact the insurance company to confirm whether or not you have a conversion right.

If you are eligible and choose to pursue an individual conversion policy, the insurance company must receive your application and first payment within 31 days of notifying you of your conversion options.

With an individual conversion:

• The policy is continued through the current insurance company.
• You cannot be denied or experience a benefit waiting period due to a pre-existing condition.
• You will not have a lapse in insurance - the individual conversion policy will begin the day after COBRA or PA Mini-COBRA ends.

HIPAA Conversion (Alternative Mechanism Policy)

If you are unable to convert your policy to an individual conversion policy, another option is a HIPAA conversion policy. In Pennsylvania, these policies are only available from a Blue Cross/Blue Shield company.

• You will need to provide a Certificate of Creditable Coverage from your insurance company.
• Contact a Blue Cross/Blue Shield company before your COBRA or PA Mini-COBRA coverage ends to prevent a lapse in coverage.
• When you contact a Blue Cross/Blue Shield company, ask specifically for a HIPAA conversion application.

To find a Blue Cross/Blue Shield company that serves your area, go to PAHealthOptions.com.

Learn more at PAHealthOptions.com
A pre-existing condition is a medical condition that you (or a dependent) have before you enroll in a health plan. There is no standard list of what is considered a pre-existing condition. Each health insurance plan uses its own list. Generally speaking, a pre-existing condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received.

Before purchasing a policy, be sure to learn what is considered a pre-existing condition under that plan. It may make you unable to purchase that particular insurance.

Starting in 2014, under the Affordable Care Act, insurance companies will no longer be allowed to deny coverage or exclude benefits due to a pre-existing condition. This protection is already in place for children under 19.

PA FAIR CARE
PA Fair Care is Pennsylvania’s health plan for uninsured adults with pre-existing conditions, including serious mental illnesses.

Who is eligible?
You are eligible if you meet all of the following requirements:

- You are a resident of Pennsylvania who is a United States citizen or national, or who is lawfully in the United States.
- You have been uninsured for six months prior to the date you are applying for coverage to begin.
- You have a pre-existing condition defined by the program. A list of defined pre-existing conditions can be found at www.pafaircare.com.

What will it cover?
PA Fair Care coverage includes preventive care, physician services, diagnostics, hospitalization, prescription medication, serious mental illness and more.

What does it cost?
PA Fair Care has a monthly premium of $283. Individuals are also responsible for a $1,000 deductible and co-pays.

For more detailed information on PA Fair Care, please visit www.pafaircare.com.

GUARANTEED ISSUE PLAN
A guaranteed issue plan is a plan offered by Blue Cross/Blue Shield companies. If you apply for a guaranteed issue plan, you cannot be denied health insurance because of your health status.

Guaranteed issue plans are only available to individuals who are not eligible for COBRA, PA Mini-COBRA or conversion policies. These plans do not cover the care, supplies and treatment related to pre-existing conditions for the first 12 months of coverage.

To find out more about guaranteed issue plans, contact a Blue Cross/Blue Shield company in your county. You can find a list at PAHealthOptions.com.
Other OPTIONS

If you have a low income or a disability but don’t qualify for Medicare or Medical Assistance, there are other options available.

SOCIAL SECURITY ADMINISTRATION
Federal benefits for people with qualifying disabilities who have worked in jobs covered by Social Security.

COMPASS
A site where Pennsylvanians can apply for many different health and human service programs in one easy place. (www.humanservices.state.pa.us/compass.web/CMHOM.aspx)

SPECIAL CARE HEALTH INSURANCE
Pennsylvania’s Blue Cross/Blue Shield companies offer SpecialCare, a limited-benefit, low-cost, income-based health insurance plan for individuals and families. For more information or to enroll in SpecialCare, contact a Blue Cross/Blue Shield company that provides services in your county.

Note: SpecialCare is not offered by the Pennsylvania Insurance Department, nor does identifying it here serve as an endorsement or sponsorship or other affiliation by or with the Pennsylvania Insurance Department. The SpecialCare products are offered by the Blue Cross/Blue Shield companies and these products are identified here as a resource only.

COMMUNITY HEALTH CENTERS
There are approximately 200 community health centers across the state that provide comprehensive, high-quality medical healthcare for all ages on an ability-to-pay basis. In some locations, a full range of services such as dental care and prescription drugs may be available. Services may be free or low-cost, based on your household income. To find the health center nearest you, call the PA Association of Community Health Centers, Monday through Friday, 8:30 a.m. to 5 p.m., at 1-866-944-CARE (2273), or go to http://www.pachc.com/health_find.html for a list of Pennsylvania health centers.

PRESCRIPTION DRUG FINANCIAL ASSISTANCE
Pennsylvanians who do not participate in any other state or federally funded prescription program may be able to receive free or low-cost prescriptions. Call 1-800-955-0989 for The Pennsylvania Patient Assistance Program Clearinghouse or go to www.aging.state.pa.us, “Prescription Assistance” and “Other Pharmaceutical Programs.” The Clearinghouse will help you apply for free or low-cost prescription medicines available from drug manufacturing companies and other sources.

MEDICAL ASSISTANCE FOR WORKERS WITH DISABILITIES (MAWD)
MAWD is a health insurance program for working individuals with a disability. There is no set requirement for how many hours you must work or how much you must earn, but you must work and receive wages to qualify. For more information, call 1-800-692-7462 or go to www.dpw.state.pa.us and type “MAWD” in the Site Search box in the top right corner, then click on the first link: “Medical Assistance Benefits for Workers with Disabilities.”
SELECT PLAN FOR WOMEN
Pennsylvania’s SelectPlan for Women is free, confidential health insurance for women between the ages of 18 and 44 that pays for family planning services and related preventive health screenings provided by participating healthcare professionals. Family planning-related prescriptions are free at any participating pharmacy. For more information and to see if you are eligible, call 1-800-842-2020 or go to www.selectplanforwomen.com.

HEALTHY WOMAN BREAST AND CERVICAL SCREENING PROGRAM (HWP)
HWP offers breast and cervical exams at no cost for eligible women. These exams include mammograms, clinical breast exams, pelvic exams and Pap tests. You qualify if you are 40 to 64 years old, have limited or no insurance, and have low to moderate household income. For more information and to find the HWP check-up site near you, call 1-800-215-7494 or go to www.pahealthywoman.org.

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT PROGRAM (BCCPT)
If you have been diagnosed with breast or cervical cancer or a pre-cancerous condition of the breast or cervix, you may be eligible for free health insurance for women through BCCPT. The care covers breast or cervical cancer treatment, as well as any other care needed for unrelated conditions while receiving your cancer treatment. You qualify if you are female, under age 65, meet the income requirements, and have limited or no insurance. For more information, call 1-800-215-7494.

PREGNANCY/HIGH-RISK PREGNANCY (HEALTHY BEGINNINGS/HEALTHY BEGINNINGS PLUS)
If you are pregnant, you may be eligible for Health Beginnings or Healthy Beginnings Plus - free programs that provide comprehensive maternity health insurance coverage to pregnant women and their babies for a full year. Call 1-800-842-2020 for more information on how to apply and for locations near you.

HEALTH COVERAGE TAX CREDIT
The Health Coverage Tax Credit (HCTC) was created to help pay for private health insurance for displaced workers receiving certain Trade Adjustment Assistance (TAA) benefits and individuals receiving benefits from the Pension Benefit Guaranty Corporation (PBGC). HCTC is a tax credit that covers 72.5 percent of the premium amount paid by eligible individuals for qualified health insurance coverage. For more information, call the HCTC customer contact center at 1-866-628-HCTC or go to www.irs.gov/individuals/index.htm.

SPECIAL PHARMACEUTICAL BENEFITS PROGRAM – MENTAL HEALTH
This program provides prescription drug assistance to individuals with schizophrenia who do not respond to first-line drug therapies and who are not eligible for pharmaceutical coverage under the Medical Assistance program. For more information, go to www.dpw.state.pa.us and click on “For Adults.”

SPECIAL PHARMACEUTICAL BENEFITS PROGRAM – HIV/AIDS
This program provides pharmaceutical assistance and specific lab services to low to moderate income individuals living with a diagnosis of HIV/AIDS who are not eligible for pharmacy services under Medical Assistance. Applicants must be a resident of Pennsylvania, have a gross annual income of less than or equal to 337 percent of the Federal Poverty Level and have a diagnosis of HIV/AIDS to qualify for the program. This program is a payer of last resort and third-party resources must be used before payment is made by the program. For more information, go to www.dpw.state.pa.us and click on “For Adults.”
SPECIAL KIDS NETWORK SYSTEM OF CARE
The mission of the Special Kids Network System of Care (SKN/SOC), is to improve access to services, provide comprehensive information for those seeking to identify services and to foster the improvement or development of local services for children with special healthcare needs and their families. The SKN/SOC helpline connects individuals to resources and programs specific to their needs by making access to these resources easier for Pennsylvania families and providers. For more information, call 1-800-986-4550, e-mail gotoskn@pa.gov or go to www.health.state.pa.us.

SAFETY NET DENTAL CLINICS
Safety net clinics are most often nonprofit, community-sponsored dental clinics that usually see patients without other access to dental care. These are usually low-income people who can’t afford dental care or are patients on public insurance who cannot find a dentist willing to see them. The dental treatment is either done for free or a sliding scale is offered. Each program has its own limitations and availability of appointments, so call first to find out the specifics of a clinic near you. To identify nearby clinics near you, visit www.padental.org and look under “Resources and Programs.”

LEARN MORE AT PAHEALTHOPTIONS.COM

PENNSYLVANIA DENTAL ASSOCIATION’S SENIOR DENTAL CARE PROGRAM
The Senior Dental Care Program offers reduced-cost dental care to eligible, low-income Pennsylvania senior citizens from dentists who are members of the Pennsylvania Dental Association. To learn more about the program, go to www.padental.org and look under “Resources and Programs.”

MENTAL HEALTH TREATMENT
Mental health services are administered through county Mental Health/Mental Retardation (MH/MR) program offices. The county MH/MR office determines a person’s eligibility for service funding, assesses the need for treatment or other services and makes referrals to appropriate programs to fit treatment and/or other service needs. For a list of county MH/MR office locations ad contact information, go to www.mhdspa.org.
WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?
A health savings account (HSA) is a tax-free account trust that individuals covered by a high deductible health plan can set up to save for future qualified medical health expenses.

HSAs offer several tax-related benefits and the unused monies in the HSA stay in the fund and roll over year to year. An HSA is “portable,” so it stays with you if you change jobs or stop working.

There are certain requirements that must be met to set up an HSA. For more information on HSAs, visit the IRS website: http://www.irs.gov/publications/p969/ar02.html#en_US_2011_publink1000204020.

I HAVE THE OPPORTUNITY TO SET UP A HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA). IS THIS SOMETHING I SHOULD CONSIDER?
Some employers offer the opportunity for employees to set up a flexible spending account to help pay for eligible medical expenses not covered by insurance, such as co-pays, dental work and eyeglasses. FSAs are typically funded by money taken out of your paycheck. You determine the amount that is withheld.

Your contribution to the FSA is taken out before you pay federal and state income and Social Security taxes. Most employers set a maximum amount you can contribute each year.

If you set up a healthcare FSA, it is important to plan ahead. Unlike a health savings account, money in an FSA cannot be carried over from year to year. If you don’t use the money, you lose it.

I WORK PART-TIME. CAN I STILL GET HEALTH INSURANCE THROUGH AN EMPLOYER-SPONSORED PLAN?
In Pennsylvania, employers can choose to include part-time workers (who work 17 hours per week or more) in a health plan offered to full-time employees. Be sure to ask your employer if you are able to enroll.

I JUST STARTED A JOB, BUT MY EMPLOYER SAYS I HAVE TO WAIT BEFORE I WILL BE COVERED BY THE PLAN. IS THIS LEGAL?
Some employers have new employees wait one to three months (or longer) before they are eligible to be covered by the employer-sponsored health plan. This is legal in Pennsylvania.

When accepting a new job, be sure to find out if there is a waiting period so you can be sure to avoid a gap in coverage.

WHAT HAPPENS IF I AM COVERED BY ANOTHER PLAN, SUCH AS MY SPOUSE’S PLAN, IN ADDITION TO MY OWN GROUP POLICY?
Insurance companies coordinate benefits to make sure that only one insurance is responsible to pay first. The company is called the primary payer. The second insurance company is then responsible to pay deductibles or any remaining covered balances, according to the terms of your insurance policy.

Be sure to check with your employer’s human resources office to learn how this affects you.
CAN MY INSURANCE COMPANY RAISE MY PREMIUM?
Insurance companies can raise premiums when overall costs increase. They cannot raise premiums simply because you use services or your health status changes.

Insurance companies must get approval from the Pennsylvania Insurance Department before raising rates on individual policies, or some group rates. Your company must notify you of any rate increase before it takes effect.

CAN MY INSURANCE COMPANY EVER STOP COVERAGE?
Yes, under certain circumstances, such as:

• If the premium isn’t paid.
• If you intentionally include wrong information on your application for insurance.
• If the insurance company no longer offers that particular type of coverage.

If your employer chooses to cancel the group policy it offers, the employer must notify you of the cancellation (usually 30 days in advance).

MY HEALTH INSURANCE COMPANY WON’T PAY FOR MY CLAIMS. WHAT SHOULD I DO?
1. Review your member handbook to be sure you understand the coverage you have and how the insurance company asks you to handle appeals.
2. Contact the insurance company and your medical provider to see if you can resolve the situation.
3. If you can’t resolve the situation, file an appeal with the insurance company. To learn how to file an appeal, visit PAHealthOptions.com to download “Your Guide to Filing Health Insurance Appeals.”
4. If you need more help, call the Pennsylvania Insurance Department at 877.881.6388.

Throughout the process, be sure to take good notes, including names and contact information for people you have talked to or e-mailed.

Learn more at PAHealthOptions.com
Glossary

There are many different healthcare terms used in this guide. This glossary is included as a quick reference for the key terms and acronyms within the guide. A more extensive healthcare glossary can be found online at PAHealthOptions.com.

-A-

ACA Affordable Care Act is the healthcare reform legislation signed by President Obama in March 2010.

APPEAL To ask that a health plan reconsider its decision to deny coverage.

-C-

CONVERSION The ability to switch coverage. For example, the ability to switch from job-based coverage to individual coverage when the group continuation coverage through COBRA, PA Mini COBRA or group coverage ends.

CHIP (CHILDREN’S HEALTH INSURANCE PROGRAM) The Children’s Health Insurance Program provides coverage to eligible children up to age 19. Like Medical Assistance, it is jointly funded and administered by the state and federal government.

COINSURANCE The percentage of a healthcare provider’s charge the patient is financially responsible for under the plan’s terms.

CHC (COMMUNITY HEALTH CENTER) A community-based organization that serves populations with limited access to healthcare.

COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT) Passed in Congress in 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporarily continue their health coverage at group rates. The law generally covers health plans maintained by private employers with 20 or more employees, employee organization, or state or local governments.

CDHP (CONSUMER-DIRECTED HEALTH PLAN) A healthcare plan that gives people control over their healthcare because claims are paid using a consumer-controlled account versus a fixed health insurance benefit.

CO-PAYMENT The flat-dollar amount a patient must pay when visiting a doctor or other health care provider.

-D-

DEDUCTIBLE A dollar amount that a patient must pay for healthcare services each year before the insurance company will begin paying claims.

-F-

FPL (FEDERAL POVERTY LEVEL) A federal estimate of the point below which a household has income insufficient to meet minimal basic needs.

FSA (FLEXIBLE SPENDING ACCOUNT) An account set up through your employer to pay for eligible medical expenses with tax-free dollars. There is usually a maximum amount you can contribute and any amount not used will be lost, so plan carefully.
GRANDFATHERED PLAN A health plan that an individual was enrolled in prior to March 23, 2010. Grandfathered plans are exempted from most changes required by ACA. New employees and family members may be added to group plans that are grandfathered.

GUARANTEED ISSUE A requirement that health insurance companies sell a health insurance plan to any person who requests coverage. All health insurance will be sold on a guaranteed-issue basis beginning in 2014.

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996) A federal law enacted in 1996, HIPAA protects individuals from the loss of health insurance should they lose jobs and keeps them from having to wait for coverage due to pre-existing medical conditions.

HMO (HEALTH MAINTENANCE ORGANIZATION) A type of managed care organization (health plan) that provides healthcare coverage through a network of hospitals, doctors and other healthcare providers. Typically, the HMO only pays for care that is provided from an in-network provider.

HSA (HEALTH SAVINGS ACCOUNT) Created in 2003, individuals covered by a qualified high-deductible health plan (HDHP) (with no other first-dollar coverage) are able to open an HSA on a tax-preferred basis to save for future qualified medical and retiree health expenses.

HDHP (HIGH-DEDUCTIBLE HEALTH PLAN) A type of health plan that typically requires greater out-of-pocket spending than traditional health insurance plans, although premiums may be lower.

INDEMNITY COVERAGE A traditional type of healthcare plan that offers the most freedom in making healthcare choices. You do not have to choose a primary care provider, you can choose to see any licensed physician and you do not need a referral to see a specialist. These plans are no longer common and are expensive.

INDIVIDUAL MARKET The market for health insurance coverage offered to individuals not in a group health plan.

IN-NETWORK PROVIDER A healthcare provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an HMO, PPO or POS).

MA (MEDICAL ASSISTANCE) Also known as Medicaid, MA is a joint state and federal program that provides healthcare coverage to children and adults in low-income families who don’t have family health insurance, as well as the elderly and disabled.

MEDICARE A federal program that provides healthcare coverage for all eligible individuals age 65 or older or individuals under age 65 with a disability, regardless of income or assets. Eligible individuals can receive coverage for hospital services (Medicare Part A), medical services (Medicare Part B) and prescription drugs (Medicare Part D). Together, Medicare Parts A and B are known as original Medicare. Benefits can also be provided through a Medicare Advantage Plan (Medicare Part C).

NAIC (NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS) The U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories.

NCOA (NATIONAL COMMITTEE FOR QUALITY ASSURANCE) A private, not-for-profit organization dedicated to improving healthcare quality.
OEP (OPEN ENROLLMENT PERIOD) A specified period during the year when individuals may enroll in a health insurance plan. In certain situations, such as a birth, death or divorce in a family, individuals may be allowed to enroll in a plan outside of the open enrollment period.

OUT-OF-NETWORK PROVIDER A healthcare provider (such as a hospital or doctor) that is not part of a managed care organization’s network. Depending on the organization’s rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider.

OUT-OF-POCKET LIMIT The top amount that patients are responsible for paying under a health insurance plan. This limit does not apply to premiums, balance-billed charges from out-of-network healthcare providers or services that are not covered by the plan. ACA outlines limit amounts that will adjust annually to account for the growth of health insurance premiums.

PID (PENNNSYLVANIA INSURANCE DEPARTMENT) A state organization that administers the laws that regulate the insurance industry.

PA MINI-COBRA PA Mini-COBRA law works like federal COBRA, but applies to Pennsylvania companies with 2-19 employees. You must contact your employer to receive instructions for enrolling in PA Mini-COBRA.

POS (POINT-OF-SERVICE PLAN) A healthcare plan that combines features of both an HMO and a PPO. A POS plan usually covers preventive care, individuals may not have to meet a deductible and the primary care provider is the only one who must be in the POS network.

PPO (PREFERRED PROVIDER ORGANIZATION) A type of managed care organization (health plan) that provides coverage through a network of providers. Typically, the PPO requires the planholder to pay higher costs when they seek care from an out-of-network provider.

PRE-EXISTING CONDITION A physical or mental condition including a disability for which a patient receives diagnosis or care.

PRE-EXISTING CONDITION EXCLUSION The period of time that an individual receives no benefits for an illness or medical condition under a health benefit plan. Pre-existing condition exclusions are prohibited for all plans beginning in January 2014.

PREMIUM The payment required to keep a plan in force.

PCP (PRIMARY CARE PHYSICIAN) A primary doctor who gives general medical care and provides referrals to see a specialist.

RESCISSION Rescission is the retroactive cancellation of a health insurance policy. Rescission is prohibited except in cases of fraud or intentional misrepresentation of a relevant fact.

SSA (SOCIAL SECURITY ADMINISTRATION) A federal agency that administers Social Security benefits.

WAITING PERIOD A period of time that an individual must wait, either after becoming employed or submitting an application for a health insurance plan, before coverage becomes effective and claims may be paid. Premiums are not collected during this period.
ACRONYMS

ACA Affordable Care Act
CHIP Children's Health Insurance Program
CHC Community Health Center
COBRA Consolidated Omnibus Budget Reconciliation Act
CDHP Consumer-Directed Health Plan
HHS Federal Department of Health and Human Services
EOB Explanation of Benefits
FPL Federal Poverty Level
FSA Flexible Spending Account
HIPAA Health Insurance Portability and Accountability Act of 1996
HMO Health Maintenance Organization
HSA Health Savings Account
HDHP High-Deductible Health Plan
MA Medical Assistance
NCQA National Committee for Quality Assurance
OEP Open Enrollment Period
PPACA Patient Protection and Affordable Care Act
POS Point of Service Plan
PPO Preferred Provider Organization
PCP Primary Care Physician
SSA Social Security Administration

Learn more at PAHealthOptions.com

The Pennsylvania Insurance Department’s
PAHealthOptions.com