Are you covered?

When it comes to our health, we try to cover all the bases: we eat our fruits and veggies, lather on the SPF, even exercise—but are you covered when it comes to your health insurance? According to the U.S. Census Bureau, nearly 46 million Americans are currently uninsured. Knowing your options can help protect you and your loved ones from the surprises life can throw your way.

Once you begin looking at health insurance options, it's important to find the health insurance plan that's the best fit for you. There are several options available:

EMPLOYER SPONSORED HEALTH INSURANCE If you or your spouse is working, the best plan for you is usually employer sponsored health insurance – that is the insurance offered through your employer. Benefits are generally better than you can get as an individual and costs are significantly lower than individual plans. Always look closely at your employer sponsored plan(s) and make sure you know when your employer offers Open Enrollment. Most employers only allow existing employees to enroll, or change health coverage during annual Open Enrollment. This is also the only time you can add an existing family member or significant other to your plan.

PREFERRED PROVIDER ORGANIZATION (PPO) plans provide a network of doctors, hospitals, and other health care providers and offer two levels of coverage: in-network and out-of-network. In-network care generally costs less than visiting a physician who is out-of-network, meaning your PPO plan will pay for less of your bill when you receive care outside of the specified network.

HEALTH MAINTENANCE ORGANIZATION (HMO) plans also offer a network of providers but do not offer coverage for visits to providers outside your set network. This plan generally covers the medical services for a large group of doctors, hospitals, specialists, and clinics. With an HMO, you can select your primary care physician who, when needed, can give you a referral to a specialist or hospital. HMO plans offer less flexibility than a PPO option, but are typically more affordable.

POINT OF SERVICE (POS) plans are a hybrid of an HMO and a PPO. With a POS plan, you can select a primary care physician and request referrals for specialists, yet you also have some coverage for physicians and hospitals outside your plan's provider network.

FEE FOR SERVICE (FFS) plans are the most traditional form of health insurance. Sometimes referred to as "Indemnity Plans," the FFS plan is the least common commercial insurance plan today because—despite its flexibility—it tends to be the most expensive. This option does not offer a network of providers, but instead covers specific health care services. Your FFS plan will pay for those services regardless of your selected health care provider.

Medicare is an FFS plan since Medicare recipients are allowed to use any provider with minimal restrictions and no referrals are required. If you are eligible for Medicare be sure you sign up for Part B and Part D. While Part A is automatic, it primarily covers inpatient hospital charges. You must sign up for Part B which covers doctors and other out-patient charges and Part D which is the drug coverage option. For More Information Visit: http://www.medicare.gov/navigation/medicare-basics

SOURCES:

www.census.gov
www.dol.gov
www.healthfinder.gov
www.hhs.gov
www.nlm.nih.gov

HOW A LIFE EVENT CAN AFFECT YOUR HEALTH INSURANCE

Worried about how a life event can change your health benefits? There are federal laws to protect you.

For more information on health insurance visit: www.consumerreports.org/health/insurance. Your local Spirit of Women hospital is committed to providing you with up-to-date healthcare information for you and your loved ones. Don't let life take you by surprise.

MARRIAGE—The Health Insurance Portability and Accountability Act (HIPAA) offers special enrollment rights for employees and spouses that allow them to enroll in a group health plan upon marriage. HIPAA also provides protection for individuals who have pre-existing conditions or might suffer discrimination on the basis of health status when switching plans.

PREPARING FOR BABY—HIPAA prohibits exclusions due to pre-existing conditions from being applied to pregnancy, regardless of whether the mother previously had health coverage. In addition, HIPAA does not permit pre-existing condition exclusions to be applied to newborns and adopted children who enroll within 30 days of birth or adoption.

CHANGE IN CAREER—HIPAA enables individuals with pre-existing conditions to receive or maintain coverage for a limited period, usually 12 or 18 months. HIPAA also benefits individuals who may suffer discrimination in health coverage on the basis of health status when changing jobs.

- **COBRA (Consolidated Omnibus Budget Reconciliation Act)** – Among other benefits, COBRA requires that most employer sponsored group health plans with at least 20 employees offer employees and their dependents the opportunity to continue health plan coverage for a limited period of time when the employee loses his or her job, has a reduction in hours that would result in a loss of coverage, or when a life event like divorce places a families health insurance coverage at risk.

FAILED MARRIAGE—HIPAA also ensures special enrollment rights, generally allowing employees and dependents covered under a spouse's plan to obtain coverage under the employee's plan upon divorce or legal separation, provided they are otherwise eligible.

COVERAGE FOR LOVED ONES—ERISA (Employee Retirement Income Security Act) Disclosure Provisions ensure that individuals covered by group health plans receive clear information about their rights, benefits, and obligations under the plan.