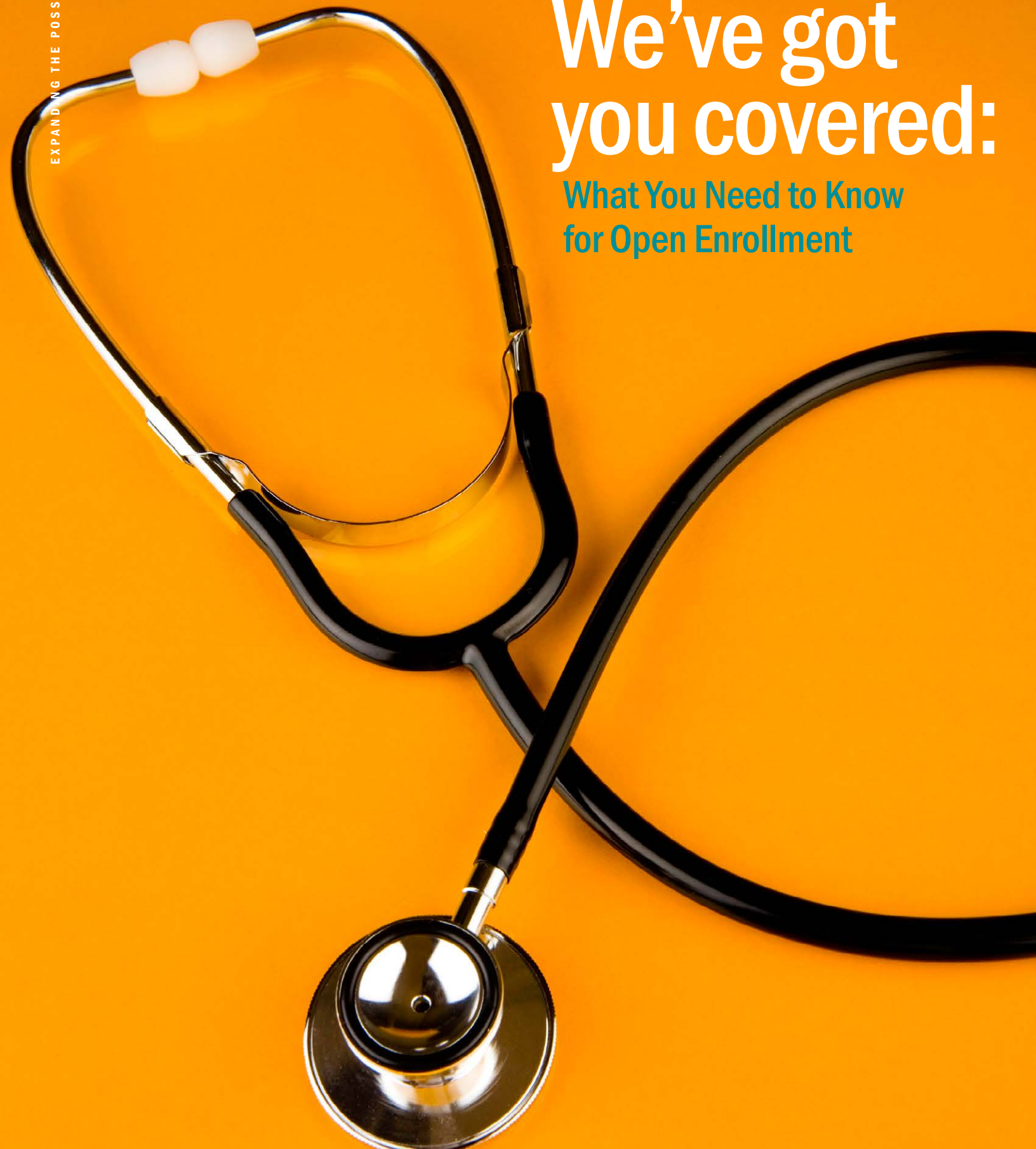
NATIONAL WOMEN'S LAW CENTER

EXPANDING THE POSSIBILITIES

We've got you covered:

What You Need to Know for Open Enrollment



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THE HEALTH CARE LAW MAKES HEALTH COVERAGE MORE AFFORDABLE AND EASIER TO BUY FOR MILLIONS OF AMERICAN WOMEN. Open Enrollment for 2016 plans begins November 1, 2015 and runs through January 31, 2016. During this time, you will be able to comparison shop for the insurance plan that best meets your family's needs and budget, and enroll in coverage for 2016. This guide to open enrollment addresses some of the questions you may have about the coverage available through the Health Insurance Marketplaces, how to enroll, and how to evaluate your health insurance needs.

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Background on Private Insurance

1. What is health insurance?

Health insurance helps you pay for medical costs such as doctor visits, prescription drugs, and visits to the emergency room or a hospital stay. Health insurance is there to protect you from unmanageable medical bills in case of a medical emergency or a serious health problem. Health insurance also covers basic medical costs related to seeing your doctor or health care provider for preventive services such as birth control, check-ups, or health screenings.

2. Why do I need insurance?

You never know when you will need medical services. If something happens to you—if you are in a car accident, need to have your appendix out or find out you have diabetes—then how will you pay for your medical care? Without insurance you could owe tens of thousands of dollars for medical care you needed to save your life or manage your condition.

3. What happens if I don't get health insurance?

If you don't have health insurance, you will probably have to pay a fine when you pay your 2016 taxes. The fine for 2016 will be $695 per uninsured adult and $347.50 per uninsured child in your household or 2.5 percent of your family income, whichever is more. There are a few exceptions to this requirement. Native Americans and certain religious communities, like the Amish, are exempt from the requirement. Other people can apply for a "hardship exemption" if they cannot afford health insurance. Check with healthcare.gov to see if you would qualify for any exemption. But remember, most people will have to pay a fine if they don't have insurance.

4. What is a premium? What is cost-sharing? What is a deductible? What is a co-payment or co-insurance?

You pay a monthly premium to the insurance company for your health coverage. You pay a premium whether you use health services or not.

When you get medical services that your plan covers, you will likely pay cost-sharing, which is the portion of the provider charges you pay yourself. First, you might have to meet a deductible. A deductible is the amount you pay for covered health care services before your health plan begins to pay your health care bills. For example, if your deductible is $1,000, your plan won't pay for your health services until you've paid $1,000 yourself. However, if you pay for services that are not part of your plan's benefit package, perhaps acupuncture or massage therapy, these payments will not count towards your deductible.

Once you meet your deductible, you will probably have to pay other cost-sharing. This might be a set dollar amount, called a copay or copayment, such as $20 or $30 a visit. Or you might pay a percentage of the allowed cost of the service, called co-insurance. Your insurance may cover a different proportion of the cost depending on whether you see a provider who is in or out of the insurance company's network of providers.

Preventive services—including well-woman visits, birth control, and breastfeeding support and supplies—are fully covered without any cost to you, even if you have a deductible. Your plan may also fully pay for other services before you meet your

deductible. Some insurance plans have a separate deductible for prescription drugs. Other plans do not apply the deductible to specific services such as office visits, generic drugs, or all prescription drugs.

It is important to understand how each plan's deductible, copayments, and coinsurance work and what they mean for how much you are likely to pay for health care throughout the year. Different combinations of deductibles, copayments, and coinsurance can result in you paying a lot, or not very much, depending on your likely health care needs.

5. What is a family deductible?

If you enroll in family coverage you will have a family deductible. Most plans have an individual deductible and a family deductible, but there are different ways family deductibles can work. It is important to know which kind of family deductible a plan includes because they can make a big difference in how much you pay for your health care.

In some plans, once an enrolled family member meets the individual deductible, the plan starts paying for covered services. The family deductible limits the overall amount a family will pay before plan coverage kicks in. For example, Anna needs outpatient surgery that will cost $4,000, and no one else in her family has used health care services in the plan year. Her family's plan has a $2,500 individual deductible and a $5,000 family deductible. Anna would pay $2,500 out-of-pocket, and for the rest of the year, she would not need to pay any more towards a deductible. If her husband later needs an x-ray, he would pay that $500 cost, because they have not yet met the family deductible. Altogether, they would pay $3,000. If he needs further care, Anna's husband would continue paying his deductible until they meet the family deductible of $5,000.

In other plans, the family has to meet the larger family deductible before the plan begins to pay. For example, Anna would pay $4,000 for her outpatient surgery, and her husband would pay $500 for his x-ray. Altogether they would pay $4,500, but together they still need to pay another $500 before they meet the family deductible and their health plan starts paying for care. (These plans will still list an individual deductible in their materials because they also sell individual coverage, so you need to look carefully at their deductible description.)

Getting Coverage

6. What if I already have insurance?

If you already have insurance either through your job, your spouse or partner's job, your school, or your parents, and plan to keep it, you don't need to make any changes. If you purchased insurance on your own or through the Marketplace, you should review your options for 2016 on healthcare.gov or your state Marketplace's website. If you buy your insurance through the Marketplace, you should also update your account with any new information about your family size and income to make sure that your monthly premium for 2016 is as accurate as possible.

7. How do I get insurance?

The Health Insurance Marketplace is a one stop shop where you can compare health insurance plans. There is a Marketplace operating in every state. Some states run their own Marketplace, and in other states, the federal government operates the Marketplace. Starting November 1, you can shop for health insurance and find out if you are eligible for financial assistance or other programs that provide low cost insurance. Even if you are not eligible for this help, you can still buy insurance through the Marketplace. You can find out where to get in-person assistance, known as a health insurance Navigator or an assister, at localhelp.healthcare.gov. Or, to apply on your own, go to www.healthcare.gov or call 1-800-318-2596.

8. Can an insurance company refuse to sell me a policy?

No. Insurance plans cannot refuse to sell you a policy, even if you do not have health insurance. Plans also can't refuse to sell you a policy even if you have had expensive health problems, or if you have risk factors for a serious health condition. They also cannot charge you more because you are a woman or because of your health history.

Buying a Marketplace Plan

9. When can I enroll?

People can shop for health insurance coverage from November 1, 2015 through January 31, 2016. This is called the "open enrollment period." During this period you can shop for insurance, compare plans, and purchase a plan. Coverage begins as early as January 1, 2016 for people who enroll and pay their first premium by December 15, 2015.

10. When does health coverage start?

You can shop for insurance options starting November 1. The date your coverage starts depends on when you enroll or renew your coverage – including picking your plan and paying any premium.

- If you enroll or renew your coverage between November 1, 2015 and December 15, 2015, your coverage will take effect January 1, 2016.
- If you enroll or renew your coverage between December 16, 2015 and January 15, 2016, your coverage will take effect February 1, 2015.
- If you enroll or renew your coverage between January 16, 2016 and January 31, 2016, your coverage will take effect March 1, 2016.

While the health care law makes sure you can get health insurance even if you are sick, you can only start your coverage during specific periods. So if you don't have insurance and get sick, you may have to wait many months before your insurance starts. Once your insurance starts, it won't pay for services you have already used.

11. What happens if I don't enroll on time?

You can only enroll during open enrollment periods. So if you don't enroll before January 31, then you will have to wait until next fall and your coverage won't begin until January 1, 2017. The exception would be if you qualify for a "special enrollment period" because you lose other health coverage, get married, divorced, give birth or adopt a child, or become newly eligible for financial assistance. You could then enroll after January 31.

12. What if I bought insurance through the Marketplace last year?

If you bought insurance through the Marketplace last year, you will receive notices from your health insurance company and from the Marketplace. These letters will tell you whether the plan you are currently enrolled in will continue, any changes to your monthly premium, and information about how your income is calculated for the financial help you may receive.

Even if you bought a plan through the Marketplace last year, you should visit healthcare.gov to update your information and consider whether you want to purchase a different plan this year. If you do not visit healthcare.gov, you could be automatically reenrolled in the same plan or another plan offered by the same insurance company you have now. However, your current plan might have a different premium next year, and a new plan could have a different premium, cost-sharing responsibilities, or network of participating doctors and hospitals than your current plan. In addition, changes in your family size or income could

change which plan is best for you. And if your insurance company is no longer offering coverage through the Marketplace, you will need to pick a new plan.

If you choose to enroll in a new plan, you should let your insurance company know you are disenrolling from your previous plan. This will ensure you are not charged a monthly premium for the plan you left.

13. What if I bought insurance from an insurance company or through a broker last year?

If you bought a Marketplace plan directly from an insurance company or through a broker last year, you will receive notices from the health insurance company and the Marketplace. These letters will indicate whether the plan you are currently enrolled in will continue, changes to your monthly premium, and information about how your income is calculated for the financial help you may receive. You should visit healthcare.gov to update your information and consider whether you want to purchase a different plan this year. If you do not visit healthcare.gov, you will be automatically enrolled in the same plan or another plan offered by the same insurance company you have now.

If you have a continuation of an old plan through an insurance company or broker, you should visit healthcare.gov to see what options are available through the Marketplace. Old plans don't always provide comprehensive benefits and there is no financial help to pay for your premiums, so you can probably find a better plan for your needs and budget at healthcare.gov. To understand your options, you can find in-person assistance, such as a Navigator who can help you find a good plan for you, through localhelp.healthcare.gov.

14. What if the plan I have now is no longer available?

If the plan you have now is no longer available, you should visit healthcare.gov to explore your options for 2016.

15. What if my income or family size changes during the plan year?

You may want or need to change your insurance coverage in some circumstances. If you become pregnant, you may be eligible for your state's Medicaid program (depending on your income). If you have changes in your family size, income, if you lose or gain a job, or if you work part-time and add or lose hours, you should check back with Navigators or other community assistance, or at healthcare.gov to see if you are eligible for more financial assistance, or a different type of insurance coverage.

What's Covered

16. What will insurance cover?

All insurance plans available through the Marketplace cover a core set of essential health benefits including maternity and newborn care, doctor visits, preventive care, hospitalization, prescription drugs, and more.

17. Will plans cover preventive services?

Many preventive services are covered without cost-sharing, which means you can get these services with no cost to you. These services include mammograms, cervical cancer screenings, diabetes and blood pressure screenings, depression screenings, and vaccinations. Plans also have to cover additional preventive services for women including birth control, well woman visits, lactation counseling and supplies, and screening for gestational diabetes.

18. Can I stay with the same doctor or clinic?

Each insurance plan contracts with a network of health care providers. They are sometimes called "participating providers" or "in-network providers." You can compare insurance plans through the Marketplace to find out which plans your doctor, hospital, or clinic has joined. Some plans only pay for services provided by doctors or other providers that are in their network. Other plans cover some of the cost if you go out of their network. However, you may need to pay the provider up-front and ask the plan to pay you back. In addition, you may end up paying more than you would to see an in-network provider because the plan will often pay less than an out-of-network doctor's charges. It can be difficult to find out the exact amount you will have to pay for an out-of-network doctor.

Paying for Insurance

19. How much will the insurance cost and when do I have to pay?

You will probably have to pay a monthly premium for your health insurance. However, depending on your income and family size, you may qualify for enough financial help that you do not have to pay a monthly premium. Otherwise, your premium will depend on which plan you choose, the number of people covered by your plan, where you live, your age, and your income. You may also get help with cost-sharing, including deductibles, copays, and coinsurance. You will need to pay your first month's premium before your coverage will start.

The Marketplace places plans into four tiers—from Bronze plans, which have the highest costs to you when you use services, to Platinum plans, which have the lowest cost-sharing. The tiers let you easily compare plans that have similar financial protections. To protect you and your family, there are limits on the maximum amount you will ever have to pay for covered services. Go to healthcare.gov or call 1-800-318-2596 to find out more.

20. How does financial assistance work?

Financial assistance helps make health insurance more affordable so more people can buy coverage. If you are eligible for this help, the money will go directly to the insurance company and you will pay less each month for your health insurance. Financial assistance is available for many middle class families— families with annual incomes up to about $80,000 for a family of three and $97,000 for a family of four will qualify for help. Families with somewhat lower incomes will also qualify for help with cost-sharing, including co-payments, co-insurance, and deductibles. Your eligibility for financial assistance will depend on your income and family size.

21. What if I don't pay on time?

You need to pay your premium each month to keep your health insurance. However, if you receive financial assistance, you will have a grace period of 90 days if you have problems paying. If you do not receive financial assistance, then you need to check with the Marketplace to find out whether or not you have a grace period. If you do not pay within your grace period, your health insurance benefits will be cancelled as of the last month that you paid for and you will be responsible the full cost of any health services you used during the grace period. You will not be able to enroll again until the next enrollment period.

Medicaid Coverage

22. Could I be eligible for Medicaid?

More than half of the states have accepted federal funding to cover more people through their Medicaid programs. If you live in one of these states, you may be eligible for Medicaid coverage, even if you have not qualified for Medicaid before. If your state has not yet expanded its Medicaid program, you may still be eligible for coverage, depending on your family situation. Check on healthcare.gov or find in-person help through localhelp.healthcare.gov.

23. What does Medicaid cover?

Medicaid coverage must include a standard package of services, including doctor visits, hospitalization, clinic visits, birth control, and many other important women's health services. People with Medicaid coverage can use health care services without paying much themselves.

24. When can I enroll in Medicaid?

You can enroll in Medicaid at any time, as long as you qualify for this coverage.

Next Steps for Open Enrollment

25. I already have Marketplace insurance. What do I do?

You will receive letters from your health insurance company and from the Marketplace. These letters will include information about changes to your monthly premium, whether your current plan will continue to offer coverage next year, and information about how your income is calculated for the financial help you may receive.

These letters will also tell you if you will be automatically re-enrolled in the same plan or another plan offered by the same insurance company you have now. Automatic re-enrollment could happen if you do not update your personal information or do not actively choose a new plan. However, you could face a different premium, cost-sharing responsibilities, or networks. And if your insurance company stops offering Marketplace coverage, you will not be eligible for automatic reenrollment. In this case, it is very important to visit healthcare.gov and learn about your choices.

Whether you like your current health plan or not, you should visit healthcare.gov to update your personal information and browse the other health plans offered this year.

As you decide whether to renew your plan or enroll in a new plan, here are a few things to consider:

- **Do you like your current plan?**
  - Have the healthcare services you needed been covered by your plan?
  - Can you afford to use your insurance, or are the payments you must make when you need care too high for you?
  - Were the specific doctors, clinics, or other providers you needed part of your health plan?
- **Are you expecting any changes to your health care needs, such as getting pregnant?**
  If you expect to see a health care provider more frequently in the future because of a new health problem or if you are expecting to become pregnant, you may want think about how you pay for insurance and medical costs. For example, would you prefer to pay more each month in premiums and have a lower deductible?
- **Have you updated the Marketplace about any life changes, including changes in income, changes in family size, or a new address?**
  Changes in hours worked, income, family size, location, and immigration status can all affect how much financial help you are eligible for. You and your family might qualify for more help to afford insurance. Be sure to update healthcare.gov about these changes so you have an accurate estimate of how much you will pay for health insurance.
- **Have you or your spouse been offered job-based health insurance?**
  If you or your spouse has an offer of health coverage through a job, you may no longer be eligible for financial help to purchase coverage on the Marketplace.

✔ How does your plan compare to others offered on the Marketplace this year?

In many places, plans on the Marketplace have changed, so it's important to compare the new plan options with the plan you have today. Some of the new plans may better fit your needs and budget.

- Is there a more affordable option for next year?
- Is there a plan that provides better coverage for your health care needs, including any prescription drugs you take regularly?

26. This is my first time enrolling through the Marketplace. What do I do?

If you don't have health insurance, or if you purchase insurance on your own, outside of the Marketplace, you can enroll in an affordable, comprehensive health plan starting on November 1 with coverage effective as early as January 1, 2016. As you prepare for your first open enrollment, here are some key questions and tips to consider:

✔ What are your health care needs?

Thinking about your health care needs should help you figure out which health plan will be best for you. Depending on how often you see your health care provider or how many medicines you take, you may want to pay higher or lower premiums, or have higher or lower costs to you when you need care. And, if you already know the providers you want to see or the medications you take, then you can check to see if the provider or medication is covered by a particular plan.

- Do you have a health condition, like diabetes, that needs frequent visits to your provider?
- Do you expect to have any major health related expenses, such as pregnancy, this year?
- Do you have prescription drugs you will need covered by your insurance?
- Do you have specific doctors, clinics, or other providers you want to have in your plan?

✔ What's your budget?

Depending on your income, you and your family may get help with your health insurance premiums, or qualify for free or low-cost health insurance. Remember that health insurance will protect you from financial risk if you get sick or need care. Insurance pays for many basic health services with no additional cost for you and if you get sick or need urgent care, insurance will pay for many of the services you'll need. Be prepared to pay your first month's premium before coverage will be effective.

- What can you afford for monthly health insurance premiums and an annual deductible?
- Would you rather pay more when you see a doctor, or pay higher premiums every month but pay less when you see a doctor?
- Would you prefer a plan with lower costs to you when you need care, but less flexibility to see specialists, or a plan with more flexibility and higher costs to you?

✔ Would in-person assistance help you understand your options and make your decision?

Choosing between health insurance plans can be difficult. If you need help applying for insurance or determining which plan is right for you, you can get assistance from a Navigator or assister at local organizations, by phone, or online. You can find this help here: localhelp.healthcare.gov.

Have you gathered important documents for you and your family? You may need:

- Social Security cards
- Income documents, such as tax returns or W2s
- Citizenship and immigration documents
- Names of your health care providers or medicines

Life Changes and Health Insurance

After open enrollment ends, you may experience changes to your family, your job, or your income that will change your health insurance needs or that may make you eligible for other kinds of health coverage.

- If you get pregnant, you may be eligible for other types of insurance. Check in with a Navigator (you can find one at localhelp.healthcare.gov) or healthcare.gov to find out about other options.
- If you give birth or adopt a child, you may be eligible for additional financial help to pay for insurance because your family sized has changed. Check in with healthcare.gov.
- If you change jobs or have an increase or decrease in salary, your eligibility for financial assistance may change. Check in with healthcare.gov.
- If you get married, divorced, or legally separated your eligibility may change. Check in with healthcare.gov.

Now that you feel prepared, it is time to get covered! It's important that you know your health insurance needs, understand your plan choices, and pick the plan that is right for you. Visit healthcare.gov for more information and to shop for health insurance.

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