OP&F Pre Medicare FAQ

1. **What is an HMO?**
    A. An HMO (Health Maintenance Organization) gives you access to certain doctors and hospitals within its network. A network is made up of providers that have agreed to lower their rates for plan members and meet quality standards. Care under an HMO plan is covered only if you see a provider within that HMO's network. There are few opportunities to see a non-network provider. Some plans may require you to select a primary care physician (PCP), who will determine what treatment you need. With some plans, you may need a PCP referral to be covered when you see a specialist or have a special test done.

2. **I don't see any Gold level plans in my area; I only see Silver. I want a Gold plan like my friend has. Is there that much more value in having a Gold plan? How do the key components of a Gold plan compare to a Silver plan?**
    A. All individual major medical health insurance plans on the market today are categorized into four tiers by actuarial level—actuarial levels represent the percentage of total expected expenses paid for by the health insurance policy. Under the Affordable Care Act (ACA), these tiers have been assigned a metal name: bronze, silver, gold or platinum and the levels vary by the percentage of costs you must pay, on average, toward the health care you receive. In general, the lower your health insurance policy's out-of-pocket expenses, the higher your monthly premium and vice versa. The ACA requires that all major medical insurance plans include the same minimal coverage for healthcare items and services in the 10 categories of essential health benefits.

3. **I lived in Ohio for 8 months and then in Florida for 4 months. If all the plans available to me are HMO's how will this impact me being covered while in Florida?**
    A. First, the retiree should purchase a plan from the marketplace in the state they consider their primary residence -- where they vote, pay taxes, and so on. Review the documentation provided and ask the insurance provider for details. Don't sign up for a plan until you're sure you understand network restriction and what services will be covered when you are outside of the service area. In most cases, an HMO plan will cover you in case of emergencies that happen out of state. All ACA plans cover emergency services at any hospital in the United States, regardless of what state plan was purchased from, with the exception of Hawaii. As long as an emergency is considered life-threatening, it will be covered as in-network, regardless if the hospital is in your plan's network.

    A retiree may also want to review additional coverage that is offered. A retiree can get additional critical illness/accident coverage that will pay money if you encounter an accident or bad diagnosis, regardless of location or network (For example, frequent travelers, or those most concerned with out-of-network emergency cost) OR you can get hospital indemnity style plans where they pay you cash to cover covered services,

including doctor's visits, second opinions, and hospital stays, etc. all with a national network. Note these plans may not be eligible for the stipend.

4. **If I choose an HMO and travel out of state for 4-5 months, what happens if I have an emergency and cannot go to an in-network hospital/doctor?**
    A. All ACA plans cover emergency services at any hospital in the United States. If the emergency is considered life-threatening, it will be covered as in-network, regardless of if the hospital is in your plan's network.

5. **If I go to and out-of-network emergency room, will the payment be counted towards my deductible for the year?**
    A. All ACA plans cover emergency services at any hospital in the United States, regardless of what state plan was purchased from, with the exception of Hawaii. If an emergency is considered life-threatening, it will be covered as in-network, regardless if the hospital is in your network. Insurance plans can't require higher co-payments or co-insurance if you get emergency care from a hospital outside your plan's network. They also can't require you to get prior approval before getting emergency room services from an out-of-network provider or hospital. Check with your health insurance company for specifics on out-of-network emergency care.

6. **I enrolled in XYZ plan a week ago, but I am having second thoughts. Can I change plans at this point or do I have to wait until next year?**
    A. Yes, you can make multiple plan selections during open enrollment, but you must complete the final plan change by the end of open enrollment. For 2019 coverage, open enrollment ends December 15, 2018 in most states.

5. **Why am I not able to use my Health Savings Account (HSA) for plans purchased through eHealth?**
    A. You can contribute to an HSA only when you are enrolled in a Qualified High Deductible Health Plan (HDHP) — generally any health plan (including a Marketplace plan) with a deductible of at least $1,350 for an individual or $2,700 for a family. When you view plans in the Marketplace, you can see if they're "HSA-eligible". If you are not enrolled in a qualified HDHP, you cannot contribute to your HSA, however, you can pay eligible expenses from you HSA account. According to the IRS, funds from your HSA may not be used to pay Health insurance premiums with few exceptions.

6. **I was told I would have to pay the $1,400 premium now for my 1/1/19 plan. Is it true that I must pay my first month's premium now for 1/1/19?**
    A. Once you enroll in a plan, you'll pay your premiums directly to the insurance company — not to the Health Insurance Marketplace. Your coverage won't start until you pay your first premium. Each Insurance company will handle payments differently, so it is important to follow the instructions from your insurer about how and when to make your premium payment. However, all carriers do require that you pay your premium first for

your coverage to start. Make sure you continue to pay your monthly premiums to your health insurance company on time. If you don't, the insurance company could end your coverage.

7. **What can I do to make my enrollment experience more efficient/effective?**
    A. Shop first on-line in your account and take notes on the specific questions on the plans that interest you.

8. **What is the average cost savings for an HMO? (if there is one)**
    A. Use the plan comparison tools provided by eHealth to determine the differences is cost for premiums and out of pocket expenses.

9. **Premiums are higher than I expected, how will I budget for this?**
    A. Consider directing your former health care deduction from your pension check to a savings account for deductibles and co-pays.

10. **What if I need specialists?**
    A. Make sure to review the carrier's policy terms and if you must change doctors, ask your present doctor for a referral from the new list.