ENTERTAINMENT HEALTH INSURANCE SOLUTIONS

WWW.EHISCA.COM

FAQ

What is Covered California?

- The Covered California Health Exchange is the government agency offering subsidized plans. The Exchange was created to assist citizens and legal residents with applying for marketplace coverage to comply with the Affordable Care Act ("ACA"). When the law was passed in 2010, each of the 50 states had to decide to either create a state-run health insurance exchange or offer enrollment through a federally operated exchange. California chose to create their own exchange and called it "Covered California"

What is the Advanced Premium Tax Credit?

- For those who are eligible, it sets a limit on how much one pays based on a percentage of their annual income. The amount of premium assistance that one can qualify for depends on age, household income and size, and the cost of affordable health care coverage in their region. Premium assistance is only available for medical plans purchased through Covered California

What are my insurance company options?

- Health plans included are Anthem Blue Cross, Blue Shield of CA, LA Care, Molina, HealthNet, Kaiser, Chinese Community Health Plan, Valley Health Plan

When can I apply for coverage?

- You have 60 days from your qualifying event to enroll for coverage. The effective date is the 1st of the month after approval.
- Open enrollment runs from November 1st through January 31st
- Policies are month to month.

What is Medi-Cal?

- Medi-Cal is California's Medicaid program that provides free or low-cost health care to eligible California residents. It is funded by both the state and federal government.
- You can enroll with LA Care, Molina, Anthem & Kaiser
- All plans are HMOs

What if I choose not to get health insurance?

- The penalty for not having health insurance in 2024 is the greater of $800 per adult and $400 per child, or 2.5% of the household's annual income. The California Franchise Tax Board (FTB) applies the penalty

When do I need to apply?

- Application should be submitted by the 15th of the month for a 1st of the following month effective date.

What is the difference between an HMO or PPO plan?

- HMO plans are usually more affordable than PPOs, with lower monthly premiums and out-of-pocket costs. An HMO plan has lower costs because you agree to use a particular network of providers.
- PPO plans typically have higher monthly premiums and higher out-of-pocket costs, but give you access to a larger network of doctors. PPO plans even cover some of the cost for most covered services received from non-network providers.

What does out of network mean?

- Out of network is a health care provider that does not have a contract with your health insurance plan.
- HMO – You can only go out of network in case of emergency
- PPO – If you use an out-of-network provider, health care services could cost more since the provider does not have a pre-negotiated rate with the health plan.

What is a deductible?

- The amount that you pay out of pocket before the insurance company starts paying for covered expenses.

What is an out-of-pocket maximum?

- The most you are required to pay in combined deductible, copayment, and coinsurance amounts for all the covered service amounts for all the covered services each year.