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Guide to Choosing Health Coverage

5 questions to consider when choosing health coverage

If you're one of the many Americans faced with the prospect of finding individual health coverage as the result of losing employer-sponsored health insurance, it can be hard to know where to begin.

This guide is designed for you.

While every situation is unique, there are some fundamental considerations that come into play when comparing your options and choosing the one that's right for you.

These are the five questions to consider when you are comparing and choosing health coverage options:

1. **How does my current situation affect my options?**
2. **What types of coverage are available to me?**
3. **What costs should I consider?**
4. **Do I need specific kinds of benefits?**
5. **What is the best way to purchase coverage?**

1. How does my current situation affect my options?

One of the main reasons health coverage can be so complicated is that everyone is different. Many plan options are available to meet the needs of people in virtually every situation.

That's why understanding your unique situation is key to uncovering the options you should be considering. Here are a few questions that can help here:

"What's my job status?"

If you're currently getting health coverage from a full-time job, there's a good chance it's your most affordable option (due to employers generally paying part of the costs). Those who have recently been laid off, changed jobs, have had reduced hours, gone freelance, etc. have some other options to consider.

"What's my household income?

If your income is under a certain amount, there are special programs in place that can help you, including Medicaid, CHIP and ACA premium subsidies.

"How old am I?"

Age can play a big factor in the options available to you. If you are over the age of 65, under the age of 65 with certain disabilities, or suffer from end-stage renal disease, you may be eligible for coverage through the federal Medicare program.

"What's my family situation?"

The makeup of your family can also help determine your options. If you are pregnant or a single parent with children and low income, you may be eligible for certain programs in some states. Additionally, you may be able to get covered through your spouse or partner if he/she has coverage through an employer.

"What's my health situation?"

Do you anticipate using medical services a lot? Or, do you plan on only using in case of emergencies? Taking an honest look at your personal health and your health journey can be key in determining what's important to you in choosing a coverage plan.

Once you've determined some of the factors in your situation, you can really start diving into what makes the most sense for you when it comes to getting covered.

2. What types of coverage are available to me?

Based on your answers to the first section, the types of coverage available start to become more focused. At this point, your options can become clearer.

Medicaid

What is it? A jointly funded, federal-state health insurance program administered by states in accordance with federal requirements. States establish and administer their own Medicaid programs and determine the type, amount, duration and scope of services within broad federal guidelines. Federal law requires states to provide certain mandatory benefits, and states may also cover other optional benefits.

Provides coverage for:

- Low-income families
- Pregnant women, children, individuals in need of long-term care, seniors and individuals with disabilities
- In some states, low-income adults ages 18-65, without dependent children

Long-Term or Short-Term Coverage?

- Long-term coverage, depending on needs related to income, family and health status

Affordable Care Act (ACA) Plans
Federal/State Health Exchange Marketplace

What is it? Plans provide Essential Health Benefits, follow established limits on cost-sharing and meet other requirements under the ACA. There are different levels of plans with silver and gold plans being more expensive than bronze plans. All qualified health plans meet ACA requirements for coverage known as "minimum essential coverage."

Exchanges are also where you can find out if you qualify for exclusive tax credits or subsidies to help offset coverage costs.

Provides coverage for:

- Most Americans

Long-Term or Short-Term Coverage?

- Long-term coverage

COBRA

What is it? The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances.

Many employers, but not all employers in all circumstances, are required to offer COBRA coverage when laying-off employees.

The coverage provided generally is the same coverage that was in place immediately before the qualifying event, and qualified individuals may be required to pay the entire premium for coverage up to 102% of the cost of the plan.

Provides coverage for:

- Workers and their families who lose their health benefits provided by their group health plan through their employer
- Includes voluntary or involuntary job loss, reduction in hours worked, transition between jobs, death, divorce and other life events

Long-Term or Short-Term Coverage?

- Short-term coverage (often 12-18 months maximum)

Short-term Limited Duration Insurance

What is it? These plans bridge gaps in health coverage for a limited period of time. The durations allowed will vary by state, often 6 months or up to one year. (Some states also allow up to 36 months.) Depending on your state, there are different restrictions and limits to coverage. Be aware that these plans are medically underwritten, usually don't cover pre-existing conditions and are not required to offer the same levels of coverage as an ACA plan available on the Federal/State Health Exchange Marketplace.

Provides coverage for:

- Generally, any adult up to age 65 whose application is accepted by the insurance company. Family coverage may also be available. Qualifications vary by state.
- Not everyone will have their application accepted because plans are medically underwritten.

Long-Term or Short-Term Coverage?

- Short-term coverage (timeframe allowed will vary by state and by purchaser's choice)

Medicare

What is it? Medicare has 4 parts:
Part A covering hospitalization
Part B covering medical services
Part C covering the same as Parts A & B with additional coverages
Part D covering prescription drugs

Provides coverage for:

- Over the age of 65
- Under the age of 65 with certain disabilities
- Suffering from end-stage renal disease

Long-Term or Short-Term Coverage?

- Long-term coverage, depending on needs related to income, family and health status

CHIP

What is it? The Children's Health Insurance Program (CHIP) provides health coverage to eligible children. In some states, CHIP also covers pregnant women. CHIP is a joint federal-state program that provides low-cost health coverage to children in families that earn too much to qualify for Medicaid, but not enough to buy private insurance.

Provides coverage for:

- Children and some pregnant women
- Families that earn too much to qualify for Medicaid, but not enough to buy private insurance

Long-Term or Short-Term Coverage?

- Long-term coverage, depending on needs related to income, family and health status

After reviewing your available options, you can start to estimate what costs (if any) you'll be paying throughout the year.

3. What costs should I consider?

The goal is to maximize your dollars for the highest quality care, and there are different cost factors to consider when setting out to accomplish this. Here are the main ones to look at.

Premium
The amount you pay, usually monthly, for your plan. Premiums are a fixed amount you pay, whether you use health care services or not.

Copayment (or Copay)
A copayment, or copay, is the fixed amount you pay each time you see a network provider. Some plans require you to pay copays instead of meeting a deductible. Other plans may require you to pay both a copay and meet a deductible. Keep in mind, copays do not count toward the deductible amount, but do count toward your out-of-pocket limit.

Coinsurance
Coinsurance is the amount shared by you and your plan for health care costs, calculated as a percentage. For example, if the health plan's allowed amount for an office visit is $100, and you've met your deductible, your coinsurance payment of 20% would be $20.

Deductible
The deductible is the amount of health costs you are responsible for before the plan starts sharing costs. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health services subject to the deductible. The deductible may not apply to all services. If you have a family, many plans have both an Individual Deductible and a Family Deductible. Check the plan to see how cost-sharing works when you meet one or both deductibles. However, some plans may not have a deductible but instead require copayments. Your premiums do not count toward your deductible amount.

Out-of-pocket limit
The out-of-pocket limit (OOPL) is the total amount of health costs you are responsible for before your plan pays 100% of covered health costs for the rest of the year. If you have a family, some plans include both an Individual OOPL and Family OOPL. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Generally, copays, your deductible, coinsurance and covered network payments count toward this limit.

With your type of coverage identified, along with the costs that may be associated with it, you can really start to understand how to factor what you'll be paying into your budget.

4. Do I need specific kinds of benefits?

Some plans exist mainly to cover you in the case of an emergency. Others open you up to a whole world of wellness programs and benefits designed to keep you healthier longer.

Pharmacy and prescription drug benefits

If you've ever needed prescription drugs, you know they can play an important role in keeping you healthy. Maybe you take regular medications — or maybe you've only needed medication for specific treatments. No matter what, it's helpful to know how your benefits work. Short-Term Limited Duration Insurance often does not include outpatient prescription drug coverage. If you have routine prescription drug needs, you may want to look into another health coverage option or consider additional coverage for prescriptions.

Wellness programs

Some health plans include wellness programs to help you live a healthier life. By completing daily or monthly fitness goals, you may earn rewards to use toward fitness gear and other healthy living products.

Vision and dental benefits

Dental and vision benefits are often not included within many health coverage options. If they are important to you, consider purchasing a separate, standalone dental or vision plan.

Supplemental insurance plans

Life's full of unexpected moments. Planning ahead with supplemental insurance, also known as specialty plans, can help you feel more ready to handle the medical costs and out-of-pocket expenses that often accompany these unexpected events. Choose from a wide variety of plans, coverage, deductibles and benefits so you have coverage to fit your health needs and your financial situation. Examples of specialty plans include dental, vision, life insurance and more.

Identifying what additional benefits are important to you can help you choose a coverage type that makes sense for your needs.

5. What is the best way to purchase coverage?

We're here every step of the way to help you through any questions you may have. Get Covered is your resource to help simplify health insurance with straightforward **answers** and **help** to compare your options to find the plan that works for you. No matter who you are, we're here to help you **get covered.**

Call 844-283-1345 or click here to get started.