How to Buy HEALTH INSURANCE

A buyer's guide for individuals seeking to purchase health insurance for themselves or their family.

nevada health link

connecting you to health insurance

Nevada Division of Insurance

Talk to us. We're here to help

Getting Started

So many of us forget about health insurance until we need to use it. Even when we have insurance, sometimes we forget about the routine and preventive services that help us to get and stay healthy. It isn't just an expense; it is a plan. It is also an important decision.

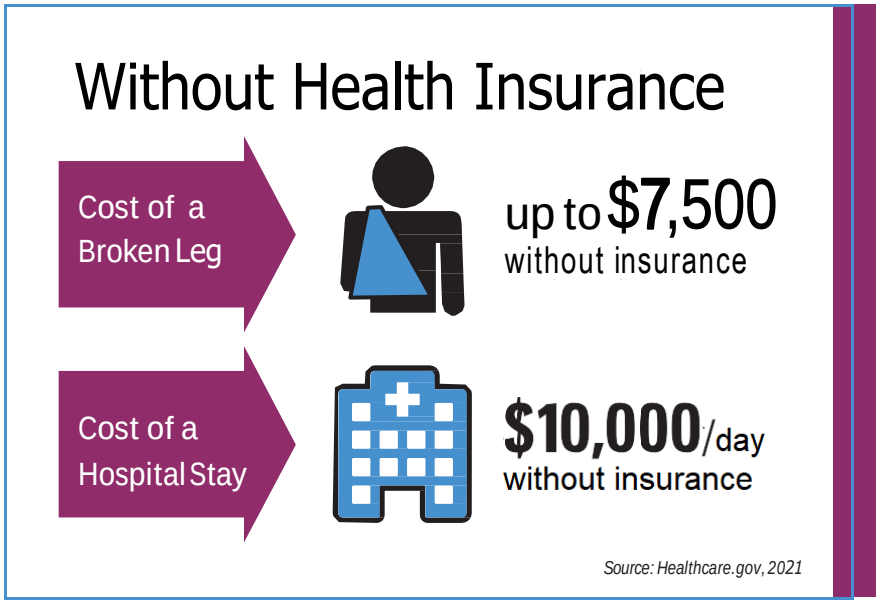
The Nevada Division of Insurance and the Silver State Health Insurance Exchange are here to help you choose a plan that is right for you. In the next few pages you will learn about the different types of health insurance, when to purchase insurance, important things to look for, and where to go to complete your purchase.

Why Everyone Needs Insurance

Many people who feel very healthy, are active, and practice healthy behaviors, may think they do not need insurance, especially due to the cost. Part of staying healthy is receiving essential routine and preventive services. Even if you look and feel healthy, you may not be getting the routine care you need to identify the unexpected such as:

- Routine lab work used to prevent, diagnose and control chronic conditions such as diabetes;
- Immunizations to avoid illness such as the measles or tetanus; and
- Cancer screenings that can result in earlier detection and treatment such as a mammogram or prostate exam.

Without insurance, we often avoid thinking about selecting a primary care physician or developing a plan for settling hospital bills. Let's face it, life is full of surprises. Insurance helps you prepare for the unexpected, like your child contracting a common infection which requires antibiotics such as strep throat, a do-it-yourself project accident that could require stitches, or a slip on winter ice. Things like this can happen to anyone, which is why it is critical to be prepared and protect yourself and your family. Sometimes having insurance might motivate us to *use it* to take better care of ourselves. Having insurance reduces stress in our daily lives in knowing we have a plan for the "what-ifs" of the future. Everyone needs health insurance.



When is the Right Time to Buy Insurance?

You can usually only shop for insurance on the Silver State Health Insurance Exchange during a specific time frame that occurs once a year called **open enrollment.** During open enrollment, you can purchase a new plan or change your insurance plan. Open enrollment typically starts in November and ends in January. You can find the dates of the next open enrollment on the web at Nevadahealthlink.com, which is the health insurance exchange website operated by the Silver State Health Insurance Exchange, a marketplace where you can buy insurance. You can also compare options and costs by visiting http://www.doi.nv.gov.

You can usually only shop for health insurance during a specific period of time called open enrollment.

Even if you already have insurance, open enrollment is a great time to update your insurance and make sure your current plan is the best plan for you.

A health plan can be purchased outside of open enrollment if you experience certain qualifying life events (QLE), such as losing coverage from an employer, moving, getting married, or having a baby. If you do not experience one of these QLEs, you must wait for the next open enrollment period to purchase a policy through the Exchange. Off-Exchange carriers can be found under the Health Insurance Rates tab at doi.nv.gov.

All health insurance plans provide guaranteed renewal of coverage, which means that you can stay in the plan you have if you like it, and the insurance company still offers it. The costs of your health plan can change from year to year. To see if your costs are increasing and look at other options, check Nevadahealthlink.com to find out if there's a better plan available for you. The Nevada Division of Insurance (DOI) reviews these plan changes and their costs every year. If you would like to learn more about this process or comment on proposed changes, visit the DOI website at doi.nv.gov.

The Affordable Care Act requires that all preventive health care services are made available to consumers at no cost.

What Does Insurance Cover?

Insurance plans help you pay for the things you need to get healthy and stay healthy, including visits to doctors and other providers, prescription drugs, and help during an illness. Any new plan you purchase covers some or all of the cost of the following basic items and services, although it is important to know certain services require prior approval from your health plan before you get them. The covered services are:

- Hospitalization
- Specific prescription drugs
- Emergency services
- Outpatient care (care outside of a hospital stay)
- Preventive services such as immunizations, pap smears, mammograms, and blood pressure screenings
- Mental health and substance use disorder services such as counseling and psychotherapy
- Wellness services such as disease management
- Care throughout pregnancy (pre-natal/delivery/post-natal)
- Basic laboratory services
- Pediatric services
- Rehabilitative and habilitative services and devices such as wheelchairs and speech generating devices
- Contraceptives
- Pediatric dental and vision care for children 18 and under

While all of these items are covered by every plan, there are differences in how plans cover the costs of these items. You can learn about these on the next page of this guide.

Some plans may also offer additional services such as adult dental and vision care, family planning services, cancer screening and more.

Regardless of which plan you choose, the Affordable Care Act requires that all preventive health services are made available to consumers at no cost. You should not be charged for these services.

Primary Care Providers

Sometimes the way you access different kinds of doctors and other providers can vary by what type of insurance plan you have. Understanding how the different models work is a good way to start thinking about which plan is right for you.

For example, some insurance plans require you to see your primary care physician and obtain a referral in order to see a doctor for specialized services. It is your responsibility to select a **primary care provider (PCP).** Examples of these models are a Health Maintenance Organization or **HMO** or Exclusive Maintenance Organization or **EPO**. These models focus on ensuring that a healthcare provider is managing all of your care through a single point of coordination, your PCP.

Other insurance models allow you to see certain doctors, providers, or specialists at any time. One example of this model is a Preferred Provider Organization or **PPO.** PPOs focus on direct access to providers that are part of the insurance plan or network. While you should always have a PCP, if you have a PPO you will not need your PCP's approval to see other types of providers. However, some services, such as a CAT scan or certain procedures, may still require special authorization.

Consider how often you visit a doctor. Do you see your PCP or specialists more often? Your answer can help you decide if a PPO or HMO is better for your needs.

How Do I Know Which Plan to Choose?

There are three main questions to ask that will help you narrow the search for the right plan:

1 Do you need access to a specific doctor or other care provider?

The doctors and other caregivers a plan works with is called the **plan provider network.** You will pay less to see providers that accept the health insurance plan you buy. This is called **in-network.** You will pay more to see providers that do not accept your health insurance plan. This is called **out-of-network.** Each insurance company publishes a list of the providers available in their plan on their website. That list is called a **provider directory.** If you like the doctor you have, you can ask your doctor which insurance plans they accept or you can check these directories at any time to see if your doctor is in-network.

Some plans have more providers in their networks than others. Plans with more doctors tend to cost more while plans with fewer doctors cost less. Think about how much you want to pay and how much you value options for the providers you see when deciding whether a plan's network is right for you.

2 Do you need a specific medical service or prescription drug?

If you need a special type of medical service or take a specific prescription drug, you can also check that the service or drug is covered under the insurance plan you are considering. You can see if a medical service is covered by reading the plan's **Schedule of Benefits** (SOB), which is a short, easy-to-understand summary of a plan's benefits and coverage. Every plan offers an SOB when you're shopping, and you'll find a link to each plan's SOB at doi.nv.gov. This is located by clicking Search for Health Insurance Rates under the Health Insurance Rates tab. Instructions on how to find the plan's SOB, Evidence of Coverage and carrier Contact Information is also located under the Health Insurance Rates tab.

The list of drugs covered under an insurance plan is called a **formulary.** Like the provider directory, plan formularies are available online. Plans often categorize drugs in terms of preferred or non-preferred. If a drug is preferred, it may mean that the fee paid when you fill the prescription is lower.

3 What mix of costs and fees work best for you?

Let's look at the different costs you will pay for your health insurance.

Monthly Premiums

When you buy insurance, the monthly bill from your insurance company is called a **premium.** Sometimes a premium is called the sticker price, like when you buy a car, because it's the first price you see, but it is not the total cost of your healthcare.

Insurance companies set a base rate for everyone who buys a health insurance plan and then adjust that rate based on just a few things: the number of people in your family you are shopping for, age, location, and tobacco use. The final calculation to the rate as it applies to you, taking those factors into consideration, becomes your fixed rate, or monthly premium.

Insurance companies can no longer charge you a higher premium based on your health status or due to pre-existing medical conditions.

We know that premiums are up-front monthly costs. The other costs – copays, deductibles, coinsurance, and out-of-pocket limits – are costs paid when you receive care. Generally there is a trade-off in monthly costs and the costs you pay when you receive care. The higher the monthly premiums, the lower your costs will be when you receive care.

> Insurance companies can no longer charge you a higher premium **based upon your health status**.

Copays

Fees charged at the time you receive service, whether a trip to the doctor or picking up a prescription at the pharmacy, are called **copays.** Copays can be different depending on the type of service you receive. For instance, a copay to your in-network doctor might be $20. A copay for a specialist might be $45. A copay to your pharmacy might be $5 for a preferred drug versus $10 for a non-preferred drug.

Deductibles

A **deductible** is the amount you need to pay first before your insurance company will begin to cover the cost of your care. Premiums and copays usually don't count toward your deductible. Also, deductibles do not apply to all services. Most plans cover routine visits, necessary prescription drugs, and preventive care outside of your deductible. Once you've met your deductible, you and your insurance company share the cost of your care until you've met your out-of-pocket limit.

Coinsurance

Coinsurance is similar to a copay. It is a charge due at the time of a specific (and usually less routine) service, such as hospitalization, but as a percentage of the cost of that service instead of a fixed fee.

Out-of-Pocket Limit

The **out-of-pocket limit** is the most you will have to pay each year for covered services outside of your monthly bill/premium. The federal government tells health insurance companies how high they can set the out-of-pocket limits. In 2022, the out-of-pocket limit for an individual could be no more than $8,700 and no more than $17,400 for a family, although many plans offer out-of-pocket limits lower than these. Once you reach the out-of-pocket maximum, insurance pays for 100% of your medical care (for in-network covered services only), although you will continue to pay your monthly premium. Out of network services are covered differently and often result in significantly higher out-of-pocket costs. Check to see how your plan covers these services before seeking care from an out-of-network provider.

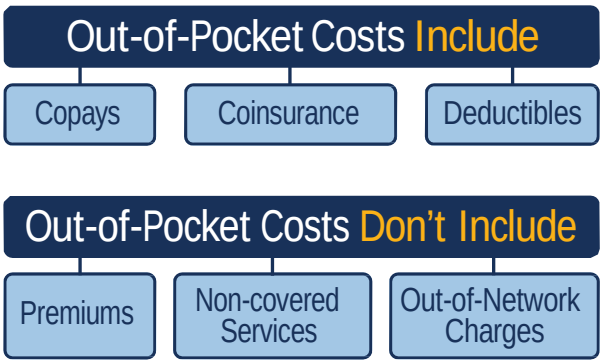
Balancing Costs

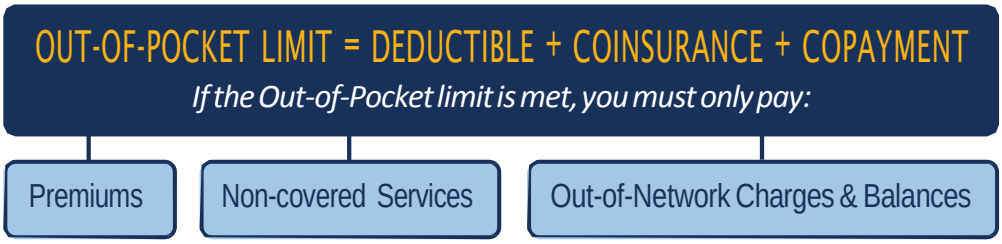
How do these costs fit together? The illustrations below are examples that may help you understand these costs.

Keeping Track

Your insurance plan keeps track of your costs. Each time you use your insurance, your insurance company sends you a statement that tells you how you used your benefits. It is like a receipt. This is called an **Explanation of Benefits (EOB).** An EOB will tell you how much your provider charges, how much the insurance plan will cover, and how much you are responsible for/owe your provider. It will also tell you how far along you are in meeting your deductible and out of pocket limit. If you are asked to pay for costs, other than your monthly premium, once you've reached your out-of-pocket limit, you should contact your insurance company.

Remember there is a trade-off between monthly costs and the costs you pay when you receive care. That means that generally insurance plans with low premiums have high deductibles and out of pocket limits, and vice-versa. Once you find the balance in costs that you think is best for you, it can be easier to select a plan using a system called metal levels.





You can stop paying copays, deductibles and coinsurance once your out-of-pocket limit is met.

Each metal level, (shown in the chart above), represents the percentage of costs you and your health plan share, outside of your premium, based on an average. For instance, someone with a bronze level plan can expect to pay 40% of their health- care cost on average each year, silver 30%, gold 20%, and platinum 10%, with the health insurance plan covering the rest. Depending on how you use your insurance and the amount of monthly costs you can afford, one of these options may be a better fit.

Can I Get Help Paying for Insurance?

There are several ways in which you may qualify for assistance to help lower your health care costs. The Affordable Care Act includes two ways for you to reduce your costs called **subsidies.** The first subsidy reduces your premium and is called the **Advanced Premium Tax Credit (APTC).** The APTC is based on family size, the estimated household income for the coming year, and the average price of insurance plans. If you qualify for an APTC, you may choose to receive the subsidy as a tax credit, or send the information about your subsidy directly to your health plan through the Exchange, where they will apply it to your monthly premium as a credit lowering your monthly premium. You will receive a 1095 form to file with your annual tax return from the Health Insurance Exchange to reconcile your income if you qualify for an APTC. This form must be filed to ensure your qualifications and credits are accurate. This may also result in owed taxes or an additional refund or credit if your income was higher or lower than expected for the year.

Many people who think they don't qualify for a subsidy actually do.

The second subsidy is called a **Cost-Sharing Reduction (CSR).** Individuals and families whose household income falls between 138%-250% of the Federal Poverty Level are eligible for cost-sharing reductions (or CSRs) if they are eligible for a premium tax credit and purchase a silver plan through the Exchange. People eligible for cost-sharing reductions will automatically receive a version of the plan with reduced cost-sharing charges, such as lower deductibles, out-of- pocket maximums or copayments.

Unlike the premium subsidies, cost-sharing reductions are not provided as a tax credit and they do not have to be "reconciled" when people file their taxes for the year the cost-sharing reductions were received.

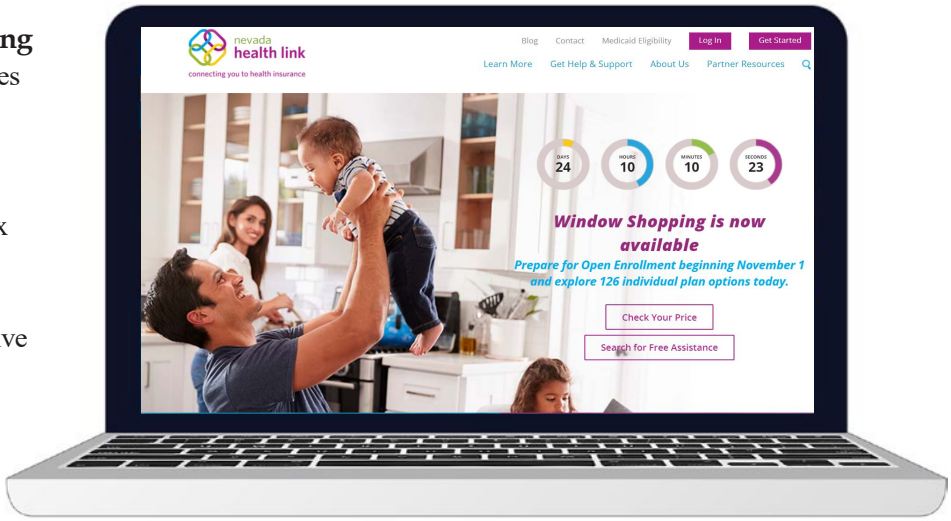
Many people who think they don't qualify for a subsidy actually do. For example, a family of four with an income level of $100,000 in 2022 qualifies for a subsidy to lower their premium. The only way to receive a subsidy is to purchase your insurance through the marketplace on Nevadahealthlink.com.

Depending on your circumstances or income level, you may also qualify for other assistance such as the **Federal Medicare Program, Medicaid (Medical Assistance or MA) or the Children's Health Insurance Program (CHIP).** If you qualify, Nevadahealthlink.com will provide you with more information on the programs that are offered by the State of Nevada.

Where to Buy Insurance in Nevada

Now that you know all about what to look for when you are choosing your plan, let's talk about where you can go to buy health insurance.

Doi.nv.gov is a great place to compare multiple plans and options, and find health insurance policies not available through the Exchange for families that do not qualify for subsidies.



Nevadahealthlink.com is the site where you can get information regarding eligible subsidies to help you and your family pay for your individual health insurance.

Nevadahealthlink.com can also connect you with licensed **enrollment professionals** who are certified and trained by Nevada Health Link. These insurance professionals will help you apply, enroll, and answer your questions. These professionals are available to provide face-to-face assistance, that is free of charge.

Nevadahealthlink.com consumer assistance call center is ready to answer questions and assist you in finding an enrollment professional. You can find a list to contact enrollment professionals in your area directly on Nevadahealthlink.com. You can also complete your purchase by logging into your account on NevadaHealthLink.com.

Please be cautious if unexpectedly solicited for health insurance. As in all other industries, this can be an opportunity for fraud. Do not supply any financial or private information until you are sure of the organization's credentials. You can verify if they are licensed at doi.nv.gov.

Buyer's Checklist

Now that you know why insurance is important, when to look for a plan, basic items and services included in a plan, important things to consider, and where to purchase a plan, you are ready to shop! This checklist may help you review and prepare for your purchase.

- ☑ Make sure the providers and services important to you are available in the plan you are considering.
- ☑ Review your monthly and annual budget to determine your price range and the right combination of costs. You can use metal levels as a guide.
- ☑ Consider shopping through the Nevada's Health Insurance Exchange. You may be surprised to find that you qualify for a subsidy to lower your costs.
- ☑ Make sure you have continuous coverage and always renew or purchase your insurance during open enrollment.

Happy Shopping!

To check your options, buy insurance, or get help find coverage, visit:

nevada health link
connecting you to health insurance

Web . . . . . www.nevadahealthlink.com
Email . . . . . CustomerserviceNVHL@exchange.nv.gov
Phone 1-855-7NVLINK (855-768-5465)

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Talk to us. We're here to help.

Web . . . . . www.doi.nv.gov
Phone . . . . . (888) 872-3234 toll-free or (775) 687-0700

Additional Resources

Medicare.gov
The Official U.S. Government Site for Medicare

Web . . . . . www.medicare.gov
Phone 1-800-MEDICARE

State of Nevada
Department of Health and Human Services
Helping people. It's who we are and what we do.

Nevada Medical Assistance (Medicaid)
Web . . . . . https://dwss.nv.gov/Contact/Welfare/
Phone . . . . . (877) 543-7669

Nevada Check Up (CHIP)

low-cost, comprehensive health care coverage to low income, uninsured children (birth through 18)

Web . . . . . https://dwss.nv.gov/Medical/NCUMAIN/
Phone . . . . . (877) 543-7669

The Nevada Division of Insurance is very grateful to the Pennsylvania Department of Insurance for granting us the use of their content in this guide