A CONSUMER'S GUIDE TO
BUYING YOUR OWN HEALTH INSURANCE

Buying health insurance can feel overwhelming if you have many choices. The tips in this guide will help you understand how to move forward on your own or with the help of an insurance agent, broker, or producer.

Government-Sponsored and Employer-Based Coverage

Before you buy health insurance, it's worth it to check if you're eligible for coverage through a government program or an employer.

- Medicare: If you're 65 or older, have received Social Security Disability Insurance benefits for at least 24 months, or have End Stage Renal Disease or Lou Gehrig's Disease (ALS), then you likely qualify for Medicare. To find out more, contact [the name of your state's SHIP program] at [your state's SHIP program phone number] or an insurance agent, broker, or producer approved to sell Medicare-related plans.
- Medicaid: Medicaid serves people who qualify based on their income. It pays for comprehensive health care at little or no cost. If you think you might qualify for Medicaid, call [name of state Medicaid agency] at [state Medicaid phone number] to learn more. People who qualify for both Medicaid and Medicare can receive benefits from both programs.
- Employer-Sponsored Coverage: Many employers offer health insurance as a benefit to employees, their spouses, and dependents. Check with your or your spouse's employer to find out about eligibility, coverage, and costs.

1. Know Key Terms Before You Shop

- **Premium:** What you pay each month for your health plan's coverage.
- **Deductible:** The amount you pay out-of-pocket before insurance starts paying.
- **Copayment (Copay):** Fixed fee per doctor visit, hospital day or stay, or prescription. For example, $20 for a doctor's visit or $30 to see a specialist.
- **Coinsurance:** The percentage of costs you pay. For example, 30% of hospital charges.

- **Out-of-pocket maximum:** The most you'll pay each year before insurance covers 100%. Not all plans have an out-of-pocket maximum.
- **Annual or lifetime limit:** The most a health plan will pay each year (annual) or in total over the time you have the plan (lifetime) toward your covered health costs. After you reach that amount, the plan won't pay any more of your health costs. Health plans subject to the Affordable Care Act don't have these limits.
- **Provider:** An individual or facility that provides health care services.
- **Network:** The facilities, providers, and suppliers (such as pharmacies) your health insurer has contracted with to provide health care services. If your health plan uses a provider network, then you pay less if you see a provider in the network.
- **Pre-existing condition:** A health problem like asthma, diabetes, or cancer you had before your health insurance went into effect. Some health plans don't cover services to treat pre-existing conditions.
- **Health insurance navigator:** A trained professional who provides free unbiased help to understand and enroll in Marketplace plans **[If applicable, replace with name of Marketplace plans in your state].**

2. Find Which Type of Health Plan Is Right for You

- **Marketplace Plans [If applicable, replace with name of Marketplace plans in your state]:** If you're younger than 65, you should look into these plans. You may qualify for financial help to reduce your monthly premium or your out-of-pocket costs. Law requires Marketplace plans to cover a comprehensive range of services, also called the 10 "essential health benefits." **[link to https://www.healthcare.gov/coverage/what-marketplace-plans-cover/]** The 10 essential health benefits are:
    - Outpatient care
    - Emergency services
    - Hospitalization
    - Maternity and newborn care
    - Mental health and substance use disorder services
    - Prescription drugs
    - Rehabilitative and habilitative services and devices
    - Laboratory services

- Preventive and wellness services
- Pediatric oral and vision care

Marketplace plans must cover services to treat pre-existing conditions. To find out more, contact [phone number for Marketplace plans in your state], an insurance agent, broker, producer, or a health insurance navigator. **[Add link to Marketplace or navigator resources.]**

- **Short-Term, Limited Duration Plans:** These plans offer coverage for up to 3 months. They don't have to cover all of the essential health benefits or services to treat pre-existing conditions.
  [Drafting Note: Adjust the definition according to state law or changes in federal policy.]
- **Other Types of Health Insurance:** You can buy other types of health insurance plans but they may not cover the essential health benefits. You also can't get financial help to pay premiums or out-of-pocket costs with these plans. Some insurance plans only cover a few services or specific conditions. Some pay you directly a fixed amount that's not related to your health care costs. For more information about other types of coverage, click here. **[Link to Types of Health Coverage Table]**

Other Types of Coverage That Are NOT Insurance

- **Health Care Sharing Ministry Plans:** Faith-based organizations sponsor these plans. They are not insurance plans. These plans use part of plan members' contributions to pay benefits. They do not guarantee how much they'll pay for the services they cover.
- **[Include if applicable] Farm Bureau Plans:** Individuals and families may qualify for coverage through the Farm Bureau, a private company. This coverage is not insurance. These plans may not cover the 10 essential health benefits or pre-existing conditions.
- **Discount Plans:** With a discount plan, you pay upfront for a discount on services from participating providers. These plans are not insurance. They do not cap the amount you may owe for health care services.

  Compare Types of Health Coverage **[Link to Types of Health Coverage Table]**

3. Watch Out for Red Flags

- **Don't rely on verbal promises.** Ask the health plan representative to give you the following information in writing:
  - What's covered
  - What's not covered
  - Costs (including premiums, deductibles, copays)
  - Keep a copy of any information you get.
- **Be cautious about unsolicited information or marketing.** Think twice before you respond to unsolicited calls, texts, or emails from unknown sources. Ask your state insurance department to confirm that insurance agents, brokers, and producers are licensed.
- **If something sounds too good to be true, it probably is.** Ads that offer comprehensive coverage for a really low price (such as $50 per month) are often misleading.
- **Approach offers of upfront payments to you with caution.** Some health plan ads or salespersons offer a gift or a government subsidy card you can use for groceries, bills, or medical needs if you sign up. These offers may be deceptive or even illegal.
- **Ask about added fees.** Fees other than the health plan premium could mean you're signing up to join an association. Know what you're paying for.
- **Avoid pushy sales tactics.** If someone pressures you to sign today or says, "this offer is expiring now," be cautious.
- **Clarify vague plan details.** Be sure to get a Summary of Benefits and Coverage or another official plan document that describes the costs and coverage in writing.

4. Tips to Follow

- **Carefully review documents before you sign.** Use the documents to check provider networks and what the plan does and doesn't cover. Carefully read anything asking you to verify your own information. Be sure you also aren't agreeing to something that limits your benefits or increases your costs.

- **Be sure you will have access to the documents after you sign.** If you sign online, be sure you can access your documents later.
- **Take your time.** Don't rush your decision. If there's a deadline, such as the limited enrollment periods for Marketplace plans, start before the deadline to give yourself more time.
- **Compare multiple plans.** Ask a trusted friend, family member, or local health navigator to review plans with you if you're not sure.

5. Ask the Right Questions

- **Is the plan an insurance plan?** If not, you may not have government protections that require the plan to pay its stated benefits.
- **Is the plan a comprehensive health plan?** Comprehensive health plans (sometimes called major medical) cover a wide range of health care services and may protect you from high costs. Other types of plans have more limited benefits.
- **Which services are and aren't covered?** Does the plan cover hospital services, primary care and specialty physician services, other medical services like lab and imaging, prescriptions, and mental health services?
- **Are your preferred providers in the network?** Check whether physicians, hospitals, or other providers you want to continue to use are in the network. Ask if there are any limits on your ability to use these providers.
- **Does the plan cover treatment for pre-existing conditions?**
- **Does the plan have an annual or lifetime limit on the amount it will pay for your care?**
- **Is there an out-of-pocket maximum that limits your total cost for deductibles, co-insurance, and copayments?**
- **Does the plan cover preventive services at no cost to you?**
- **Does the plan cover your prescription drugs? How much will you pay for those drugs under the plan?**
- **If you're dealing with an insurance agent, broker, or producer, are they licensed in your state?** States require insurance agents, brokers, and producers to meet state-specific qualifications to be licensed. If they are licensed, they have a state insurance license number. Ask for that number.

With the number, you can check that person's credentials at **[state DOI webpage for licensed producers].** Later, if you have a complaint or suspect fraud, you can report that person to **[relevant state insurance department's phone number].**

Follow this guide to be in a stronger position to get the coverage you need — and avoid falling for scams or misleading sales pitches.

Types of Health Coverage

Plan Type	What is Covered?	What is NOT Covered?	Does the Plan Pay You Or the Provider?	Is This a Marketplace Plan?
Hospital Indemnity Policy: Pays a set dollar amount for each hospital stay	Any covered hospital visit	Any services other than hospitalization	Usually pays you a set amount regardless of the amount of your hospital bill	No
Other Fixed Indemnity Policy: Pays a set dollar amount per service	Any covered service	Services for pre-existing conditions, maternity, ambulance	Usually pays you a set amount regardless of the amount your provider bills	No
Critical Illness Policy: Pays a set dollar amount per diagnosis	Any covered specific diagnosis, such as cancer	Services for pre-existing conditions, maternity, ambulance	Usually pays you a set amount regardless of the amount your provider bills	No
Disability Income Protection: Pays a set dollar amount per period if you become disabled	Any covered disability	Services for pre-existing conditions, maternity, routine physicals	Pays you a set amount depending on the policy benefits	No
Accident Only Policy: Pays a set dollar amount for covered accidents	Any covered accident	Services for pre-existing conditions, maternity, routine physicals	Usually pays you a set amount regardless of the amount your provider bills	No
Limited Benefit Policy: Pays a set dollar amount for each service	Often doctor visits, lab services, some hospital services	Services for pre-existing conditions, maternity, infertility, mental health conditions	May pay you or your provider, but the amount may not depend on the amount your provider bills	No
Vision or Dental (Limited Scope) Policy: Pays for a specific set of services within the scope of the policy	Limited services for coverage type	Services outside the scope of coverage and for pre-existing conditions, maternity, ambulance	Usually pays your provider	No
Short Term, Limited Duration Insurance: May only be available for 3 months	Limited medical services	Usually services for pre-existing conditions, maternity, infertility, mental health conditions, ambulance	Usually pays your provider	No

[Drafting Note: Adjust the definition according to state law or changes in federal policy.]				

Plans that aren't Marketplace plans may not cover pre-existing conditions or cover all of the essential health benefits. Unless you have a Marketplace plan, you aren't eligible for financial help to pay premiums or out-of-pocket costs.