Health Insurance Marketplace
Buyer's Guide

health markets

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Health insurance:
The basics

No one plans to get ill or injured, but you will probably need to see a doctor at some point in your life, even if it's just for a checkup. Health insurance helps cover medical costs and helps protect you from high expenses.

Here's how it works. Insurance is a contract between you and the insurance company. You buy a plan, and the company agrees to pay a portion of your covered medical costs if you fall ill or are injured. Many plans also cover preventive care, like vaccines, screenings and checkups. Some cover part of the costs of prescription drugs as well.

This guide will go over the basics of what you need to know when you want to purchase health insurance. Here are some common words and phrases that you should be familiar with.

Premium

The premium is the fixed amount that you pay to the insurance company, usually every month, quarterly or semi-annually. Depending on your insurance plan, regularly paying your premium may give you access to preventive care with no deductible, copayment or coinsurance.

Deductible

If you do need medical care, the deductible is the specific dollar amount you pay out of pocket each year before the insurance plan begins to make payments for claims. Once you meet your deductible, the insurance company will begin to cover some of your costs. Some insurance plans have high deductibles; others have lower deductibles. The deductible amount often impacts the premium.

Copayment

A copayment (or copay) is a fixed, flat fee that your health insurance may require you to pay your healthcare provider at the time you receive certain services. Your plan's Summary of Benefits will tell you which items have a copay and whether they are also subject to your plan's deductible and/or coinsurance. For example, your health insurance plan may require a $15 copayment for an office visit or brand-name prescription drug, after which the insurance company pays the remainder of the charges, up to its allowed amount for each service.

Copayments come in 3 varieties:

1. Copayment only: You would pay a flat-rate copay in lieu of the deductible or coinsurance. Your insurance company would pay the rest up to the allowed amount for the service.

2. Copayments after deductible: You would pay the full out-of-pocket cost for specific services until you have met your deductible, then the copay for the remainder of the year.

3. Copayment plus coinsurance: You would pay a copay at the time of service. Then, you receive a bill for your portion of coinsurance.

Coinsurance

Coinsurance is the amount that you may be required to pay for covered medical services after you have satisfied any plan deductible. Coinsurance is typically expressed as a percentage of the allowable charge for a service rendered by a healthcare provider. For example, if your insurance company covers 80% of the allowable charge for a covered service, you may be required to cover the remaining 20% as coinsurance. Please note that definitions vary across insurance plans.

Out-of-pocket maximum

This is the most you will have to pay for covered medical expenses in a plan year through copayments, deductibles, and coinsurance before your insurance plan begins to pay 100% of covered medical expenses. For example, if you have an out-of-pocket maximum of $6,000, and require surgery that costs $10,000, after you've paid $6,000 in deductibles, coinsurance and copayments, the insurance plan will pay the other $4,000, and any additional covered healthcare costs you have for the rest of the year. All covered expenses contribute to a single out-of-pocket maximum, including deductibles, coinsurance and copayments. Your plan's Summary of Benefits is required to indicate the total out-of-pocket maximum as a separate line item.

Network

An insurance network—which you might also see called a provider network—is a group of doctors, providers and hospitals that have contracted with a health insurance company. That means they've agreed to accept a prenegotiated rate for medical services or supplies they provide.

Medicaid

Medicaid is a state-administered health insurance program for individuals and families with low incomes and limited resources. It is a joint federal/state program, and each state has its own rules for eligibility and coverage, within the federal guidelines. You must be a U.S. national, citizen, or legal permanent resident in need of healthcare/insurance assistance, in a low income or very low income financial situation. You can find state-specific requirements at www.Medicaid.gov.

Medicare

Medicare is a federal health insurance plan for people who are age 65 or older, some younger people with disabilities and people with End-Stage Renal Disease (ESRD).

Health insurance and the Affordable Care Act

In March of 2010, the Affordable Care Act (ACA), also known as Obamacare, was enacted to reform the healthcare system in the United States. The goal of the ACA is to expand coverage to Americans, lower costs and increase benefits for consumers, incentivize quality and innovation in the healthcare system, and provide critical funding for public health and illness prevention. Some of the reasons behind the Affordable Care Act include:

High rates of uninsured

In 2013, 45.2 million Americans were uninsured. It was reported that as of 2024 the uninsured rate among U.S. adults was 11.5%.

Unsustainable spending

In 2010, healthcare spending represented 17.9% of our GDP. It represents 17.8% as of 2024.

Not enough prevention

With more prevention of risk factors such as obesity, high blood sugar and high blood pressure in the U.S., an estimated 12.4 million lives could be saved by 2050.

Poor health

The U.S. spends more on medical care than any other industrialized nation, but ranked 49th globally in 2022 in terms of life expectancy.

Health disparities

Inequities related to income and access to coverage exist across demographics.

The Health Insurance Marketplace was established to give individuals and families another option for purchasing health insurance. States could either choose to create their own state-based marketplaces, defer to the Federally Facilitated Marketplace or partner with the federal government to establish a marketplace. Below is a list of states that do not use HealthCare.gov, along with the name of the state marketplace:

California – Covered California
Colorado – Connect for Health Colorado
Connecticut – Access Health CT
District of Columbia – DC Health Link
Idaho – Your Health Idaho
Kentucky – Kynect (Kentucky Health Benefit Exchange)
Maine – CoverME
Maryland – Maryland Health Connection
Massachusetts – Health Connector
Minnesota – MNsure
Nevada – Nevada Health Link
New Jersey – GetCoveredNJ
New Mexico – BeWell
New York – New York State of Health
Pennsylvania – Pennie
Rhode Island – HealthSource RI
Vermont – Vermont Health Connect
Washington – Washington Healthplanfinder

Tax penalty

As of plan year 2019, there is no federal penalty for not having health insurance. However, some states have their own health insurance requirements and fees.

Subsidies

The ACA also gives additional funding to states that choose to expand Medicaid programs to cover adults under 65 with income up to 138% of the federal poverty level. Qualifying low-income residents of these states are eligible for $0 or low-cost health coverage, even if they do not meet other factors that are normally taken into account when determining eligibility for Medicaid. These are the states that have decided to expand their Medicaid programs:

Alaska	**Maine**	**North Dakota**
Arizona	**Maryland**	**Ohio**
Arkansas	**Massachusetts**	**Oklahoma**
California	**Michigan**	**Oregon**
Colorado	**Minnesota**	**Pennsylvania**
Connecticut	**Missouri**	**Rhode Island**
Delaware	**Montana**	**South Dakota**
Hawaii	**Nebraska**	**Utah**
Idaho	**Nevada**	**Vermont**
Illinois	**New Hampshire**	**Virginia**
Indiana	**New Jersey**	**Washington**
Iowa	**New Mexico**	**Washington, D.C.**
Kentucky	**New York**	**West Virginia**
Louisiana	**North Carolina**	

If your state is on this list, you will find out if you're eligible for Medicaid or a private insurance plan when you fill out a Marketplace application. If your state is not on this list and you have limited income, your options depend on where your income falls. If you make between 100% and 250% of the poverty level, you can buy a health insurance plan in the Marketplace and may qualify for tax credits or other savings. If you make less than 100% of the federal poverty level, your income won't qualify you for lower costs on private insurance. You may still be eligible for Medicaid, based on your state's rules.

Your rights & protections

The Affordable Care Act offers rights and protections to all consumers and helps make health insurance coverage easier to understand. Health insurance companies have several responsibilities that are designed to help protect consumers.

No arbitrary cancellations

Insurance companies can't cancel your coverage just because you made a mistake on your insurance application. In the past, if an insurance company found that you'd made a mistake on your application, it could take away your coverage, declare your policy invalid from the day it started, and/or ask you to pay back any money it has spent on your medical care. The ACA makes it illegal for companies to cancel coverage due to an honest mistake or because you left out information that has little bearing on your health. Your plan can still be canceled if you purposely lie or omit information on your insurance application, or if you don't pay your premiums on time.

Simplified coverage

The ACA also requires insurance companies and group health plans to provide consumers with a short, plainlanguage Summary of Benefits and Coverage (SBC) as well as a Uniform Glossary of terms used in health coverage and medical care. This is a standard format (meaning that all of the information is presented in the same order and arrangement, making it easy to identify differences) that includes coverage examples, so you can more easily compare your options.

Coverage for pre-existing conditions

Your insurance company can't turn you down or charge you more because of a pre-existing condition, and it can't refuse to cover treatment for preexisting conditions. The only exception to this is for grandfathered individual health insurance plans. If you purchased a plan yourself (not through an employer) before March 23, 2010, it may not have to cover preexisting conditions. However, you can switch to a Marketplace plan during open enrollment or after your grandfathered plan year ends.

You choose your provider

Health plans contract with a network of doctors and healthcare providers. Choosing an in-network provider will usually cost you less than seeing an out-of-network provider. You can choose any doctor or pediatrician in your health plan's provider network. If you get emergency care for a true emergency situation from an out-of-network hospital, your insurance company can't require you to get prior approval or pay higher copayments or coinsurance. This benefit does not apply to grandfathered plans.

You choose how to buy

How you purchase your plan will not affect the price. This means that whether you buy online, over the phone or face-to-face with a local agent, the premium for your desired plan will be the same.

Common network types

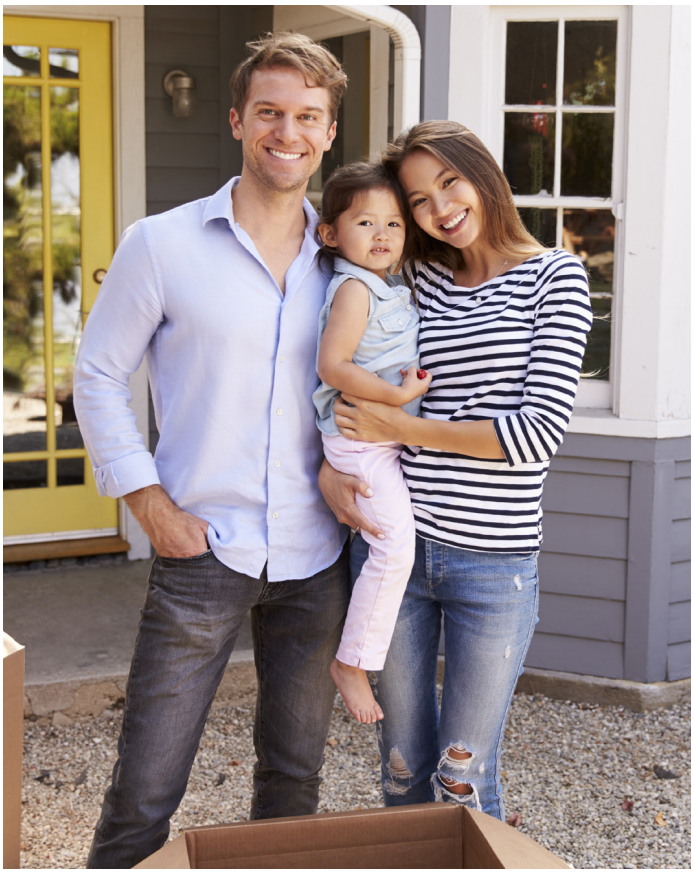
The ACA has introduced new network arrangements. Below are the common network types in ascending order by typical plan cost:

Exclusive Provider Organization (EPO) — a regional network of providers usually affiliated with a chain of hospitals. Covered individuals must stay within the plan's network to receive coverage, except for emergency situations. Generally, covered individuals may see a specialist within the plan's network without a referral.

Health Maintenance Organization (HMO) — a regional or state-wide network of providers. Covered individuals must stay within the plan's network to receive coverage, except for emergency situations. They must also designate an in-network Primary Care Physician (PCP) upon enrollment. The PCP must provide a referral before seeing a specialist within the plan's network. Per ACA guidelines effective September 23, 2010, OB/GYNs are exempt from this referral requirement provided they are in-network.

Point-of-Service (POS) — a regional network of providers. Covered individuals may use any of the in-network providers or choice out-of-network providers at a higher cost, unless it is an emergency situation. POS plans may or may not require a referral from their PCP to see a specialist. Per ACA guidelines effective September 23, 2010, OB/GYNs are exempt from this referral requirement provided they are in-network.

Preferred Provider Organization (PPO) — a network of regional, state-wide, or multi-state providers. Covered individuals may use in-network providers or choice out-of-network providers at a higher cost, unless it is an emergency situation. Due to the flexibility of PPOs, covered individuals may see a specialist within the plan's network without a referral.



Preventive care

All Marketplace plans and many other health plans are required to cover certain preventive care services without charging a copayment or coinsurance, even if you haven't met your deductible.

Some of the services, which should be provided by an in-network provider, include screening for:

- Abdominal aortic aneurysm for men of specified ages who have ever smoked
- Alcohol misuse
- Blood pressure
- Cholesterol for adults of a certain age or those at higher risk
- Colorectal cancer for adults 45 to 75
- Depression
- HIV
- Obesity
- Syphilis for higher risk adults
- Tobacco use
- Type 2 diabetes for adults 40 to 70 years who are overweight or obese

The plans are also required to provide counseling regarding:

- Alcohol misuse
- Cessation of tobacco use
- Diet, for adults at higher risk of chronic disease
- Obesity
- Sexually transmitted infection (STI) prevention for adults at higher risk

Most basic immunizations are covered, including:

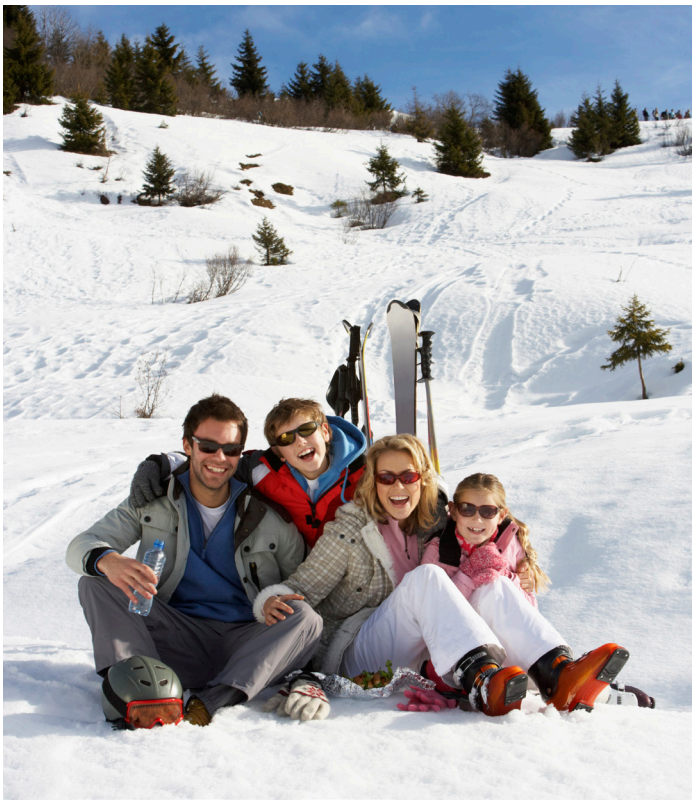
- Hepatitis A
- Hepatitis B
- Herpes zoster (shingles)
- Human papillomavirus (HPV)
- Influenza
- Measles, mumps, rubella
- Meningococcal
- Pneumococcal
- Tetanus, diphtheria, pertussis (whooping cough)
- Varicella (chickenpox)

There are several other preventive health services offered specifically for women and children. You can find a complete list of preventive care services for adults on the HealthCare.gov website, or in your insurance company's list of benefits. All services should be provided by an in-network provider.

Categories of
Coverage in the Marketplace

Most plans in the Marketplace are separated into five categories – Bronze, Silver, Gold, Platinum or Catastrophic – based on the percentage the plan pays of the average overall cost of providing essential health benefits.

The category you choose will affect the amount you'll likely spend on essential health benefits during the year, including premiums, deductibles, copayments, coinsurance and out-of-pocket maximums.



Bronze plans

Bronze plans are designed to pay for about 60% of the overall expected healthcare costs of the general population. You may want to consider a Bronze plan if you don't expect to use regular medical services and you don't take any prescription medication on a regular basis. Although Bronze plans have relatively higher out-of-pocket cost for covered medical expenses, they generally feature the most economical premiums of all the metallic tiers.

Bronze plans usually require you to meet the entire deductible before the insurance company begins to pay for covered services, except for preventive care. Most (if not all) covered services are subject to the deductible and coinsurance. They rarely require copayments on services like doctor visits or prescriptions.

Silver plans

Silver plans are designed to pay for about 70% of the overall expected healthcare costs of the general population. A Silver plan can offer the best value if you qualify for lower out-of-pocket costs based on your household size and income. You can only take advantage of these unique cost-sharing reductions on deductibles, copayments and coinsurance if you choose a Silver plan. Essentially, this will allow you to get the lower out-of-pocket costs of a Gold or Platinum plan while paying the Silver plan premium. Since most Silver plans require copays on common services such as doctor visits, urgent care and prescriptions, they are ideal for families seeking predictable costs. They are also ideal for individuals who consider themselves to be in good or average health, who may need the occasional doctor visit or prescription once or twice a year.

Gold plans

Gold plans are designed to pay for about 80% of the overall expected healthcare costs of the general population. If you need regular prescriptions or expect to have frequent doctor visits, you may want to consider a Gold plan. Although you will pay a higher monthly premium, the plan will pay for more of your costs when you need care.

Platinum plans

Platinum plans are designed to pay for about 90% of the overall expected healthcare costs of the general population. Like a Gold plan, a Platinum plan may be a good option for people who frequently see the doctor or take regular prescription medications. While Platinum plans have comparatively higher monthly premiums, they offer the lowest unsubsidized out-of-pocket cost for covered medical expenses. Individuals requiring costly treatment for chronic medical conditions may consider this option to save in the long run.

Catastrophic plans

Catastrophic plans are designed to pay less than 60% of the overall expected healthcare costs of the general population. You can only purchase a catastrophic plan if you are under 30 years of age or have a hardship exemption. Some hardship exemptions include:

- homelessness, eviction or foreclosure in the past six months,
- a natural or human-caused disaster that caused substantial damage to your property,
- filing for bankruptcy in the last six months,
- or the death of a close family member.

You can find a complete list of hardship exemptions on the Centers for Medicare and Medicaid Services (CMS) website. Catastrophic plans often have low monthly premiums, and are designed to protect consumers from worst-case scenarios, like serious accidents or diseases.

Comparing Marketplace health insurance plans

There are thousands of insurance plans available to you. How can you decide which plan is best for your budget and lifestyle? There are several important things that you will want to consider when comparing Marketplace plans.

Plan category

As discussed, these "metal level" plans of Platinum, Gold, Silver and Bronze differ based on how you and the plan will split the costs of your care. The categories have nothing to do with the amount or quality of care you will receive.

Premiums

In general, if you don't have a subsidy, the lower your monthly premium is, the higher your out-of-pocket costs will be if you do become ill or injured. If you take regular prescriptions, frequently visit the doctor or have any major health issues, you may want to consider plans with higher premiums. Make sure that you can afford your premium in the context of your overall monthly household budget.

Out-of-pocket costs

These include deductibles, copayments, coinsurance and out-of-pocket maximums. For 2025 the maximum out-of-pocket costs for any Marketplace plan are $9,200 for an individual plan and $18,400 for family plans. Even if you have a Catastrophic plan, your costs shouldn't exceed this limit. Some people may qualify for premium tax credits based on their household size and income. These people should consider choosing a Silver plan to take advantage of these tax credits.

Provider network

Different types of health plans will provide different levels of coverage for care you get inside and outside that plan's network of medical service providers. If you currently take certain prescription medications, you want to make sure that the plan you are considering covers these drugs. If you are particularly attached to your current doctor, check to see if he or she is included in the provider directory. You may have to pay more to see an out-of-network doctor.

Benefits

All Marketplace plans are required to cover certain benefits, including the preventive services previously mentioned. However, some plans offer additional benefits, like vision, dental or medical management programs for specific diseases or conditions.

How can I buy Marketplace health insurance?

Health insurance is one of the most important financial decisions you'll make each year, and it's also one of the most complicated. There are several factors that will contribute to your decision, and it can be difficult to keep everything straight.

You can apply for a health insurance plan during the annual Open Enrollment Period, which usually starts on November 1 in most states. If you miss the window of time, you may qualifty for a Special Enrollment Period if you experience specific life events. These can include, but aren't limited to, marriage, relocating to a new ZIP code or county, losing qualified coverage, and having a baby.

The HealthCare.gov website offers several tools for consumers to compare and contrast plans, but it isn't always easy to interpret how the differences between the plans will correlate to your particular situation. At HealthMarkets, a licensed insurance agent can help people find the coverage that best fits their needs and budget. All you have to do is make a call or meet with a licensed insurance agent. They can discuss your situation with you, and help you search thousands of plans to find those that meet your criteria. We guarantee you won't find a lower price anywhere for the insurance products we offer. Best of all, this personal service comes at no cost to you. With HealthMarkets, you can be confident that you've made the right choice in health insurance for you and your family.

About HealthMarkets

HealthMarkets Insurance Agency can help you understand the many health and related insurance options available so you can make the best choice. Let us help you get the right health insurance for your needs. Find a subsidy you may qualify for and apply for the plan that is right for you and your family. With over 200 insurance companies nationwide and thousands of plans to choose from, shopping for insurance has never been easier. Best of all, our service is at no cost to you!

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Your State Department of Insurance regulates the insurance products that we offer in your state and corresponding premium rates. The premiums charged by a carrier for a particular insurance product must be consistent regardless of whether you buy it from HealthMarkets Insurance Agency, from a competing agency, or directly from the insurance company.

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