Questions you should consider when purchasing a health insurance plan:

Everyone’s situation is different, and some plans may work well for one person and not as well for another person. It’s important to weigh your options and think about the answers to some of the following questions as you consider which type of plan to purchase.

1. What are my health care needs? See examples below to get a sense of how a person might answer this question. The answers to questions 2 – 7 will also inform the answer to this question.

   A. I am young/healthy, do not use a lot of medical services. I rarely visit a medical provider or require a prescription medication (1 – 3 visits per year, 1 – 2 prescriptions per year as needed, for example: generic birth control pills or antibiotics).

   B. I have a chronic condition and tend to use medical services more often. I require multiple visits with a medical provider for routine monitoring (4 – 5 visits per year, 1 – 2 maintenance prescriptions + other prescriptions like generic birth control pills or antibiotics as needed. May or may not include supplies, blood work, lab tests, etc.)

   C. I have several overlapping health concerns or conditions. I visit medical providers frequently and have maintenance prescriptions + other prescriptions like generic birth control pills or antibiotics as needed (6+ visits per year across multiple providers, 3+ ongoing prescriptions that support your medical care treatment plan)

2. Do I see a primary care provider regularly (ie. at least once/year)?

3. Do I only go to the doctor when I’m sick (ie. not very often, less than once/year)?

4. Do I see a specialist? If so, how many? How often?

5. Am I willing to pay a higher monthly premium for comprehensive coverage with minimal copays and deductibles and less out of pocket expenses (see below for definitions)?

   - **Premium**: A monthly fee you pay to your insurance company to have coverage, even if you don’t use medical services that month.
   - **Copay**: is a fixed amount you pay for covered medical services like appointments, tests, and prescriptions.
• **Coinsurance**: is a fixed percentage amount you pay for covered medical services like appointments, tests, and prescriptions, after reaching your deductible.

• **Deductible**: How much you have to spend for covered health services before your insurance plan pays anything (except free preventive services) towards the cost of your health care services.

• **Out-of-pocket maximum**: The most you have to spend for covered medical services in a year. After you reach this amount, the insurance plan pays 100% for covered services (non-covered services do NOT count towards the out-of-pocket maximum).

6. Would I prefer to pay a lower monthly **premium** for less comprehensive coverage with higher **copays** and **deductibles** and greater **out of pocket expenses** (see below for definitions)?

• **Premium**: A monthly fee you pay to your insurance company to have coverage, even if you don’t use medical services that month.

• **Copay**: is a fixed amount you pay for covered medical services like appointments, tests, and prescriptions.

• **Coinsurance**: is a fixed percentage amount you pay for covered medical services like appointments, tests, and prescriptions, after reaching your deductible.

• **Deductible**: How much you have to spend for covered health services before your insurance plan pays anything (except free preventive services) towards the cost of your health care services.

• **Out-of-pocket maximum**: The most you have to spend for covered medical services in a year. After you reach this amount, the insurance plan pays 100% for covered services (non-covered services do NOT count towards the out-of-pocket maximum).

7. What kind of prescription coverage do I need?

• Do I take any prescription medications?
• If so, how often and what kind?
• Most maintenance medications can be purchased in a 90/100-day supply
• Narcotics are dispensed for no more than a 30-day supply at one time

8. What type of health insurance plans are available where I will be living? Different plan types have different rules and restrictions, some plan types allow you to use almost any doctor or health care facility. Others limit your choices or charge you more if you use providers outside their network. See definitions below of common plan types that might be available to you:
• **Health Maintenance Organization (HMO):** A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won’t cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMO plans may require you to have a Primary Care Provider (PCP) and get a referral from your PCP in order to see a specialist. HMOs often provide integrated care and focus on prevention and wellness.

• **Point of Service (POS):** A type of plan where you pay less for a service (lesser copay, lesser co-insurance percentage) if you use doctors, hospitals, and other health care providers that belong to the plan’s network. POS plans require you to get a referral from your primary care doctor in order to see a specialist. POS plans allow you to use doctors, hospitals, and other health care providers that DO NOT belong to the plan’s network, but you pay more for a service (higher copay, higher co-insurance percentage) if you use an out-of-network provider.

• **Preferred Provider Organization (PPO):** A type of health plan where you pay less if you use providers in the plan’s network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

9. Am I willing to follow the rules and restrictions of a certain type of plan if it has a lower premium?

10. Do I want the flexibility of a plan that allows me to self-refer to any medical provider based on my situation/symptoms/needs even if it means paying a higher premium?

**In Summary:**

Generally speaking, insurance plans with higher premiums pay more of your total health care costs. Plans with lower premiums pay less of your total costs.

**If you don’t expect to use regular medical services and don’t take regular prescriptions:** You may want a plan with a lower premium. Keep in mind, plans with low monthly premiums usually require that you pay more out of your own pocket when you need care.

**If you expect to have a lot of doctor visits or need regular prescriptions:** You may want a plan with a higher premium. Having a plan with a higher monthly premium usually means that you pay less out of your own pocket when you need care.

No single plan is right for every person, only you can decide which plan meets your needs and fits within your budget. Researching the coverage and costs of options available to you using the questions above will help guide you to make the right decision for you and your family.
Alternative Health Care Options

access health CT

Access Health CT – Connecticut’s official health insurance marketplace established to meet the requirements of the Affordable Care Act, and created to help people choose and enroll in the health insurance plan that is right for their needs.

Individuals and families can review, compare, and enroll in quality healthcare plans from brand-name insurance companies like Anthem and Connecticare through Access Health CT. Additionally, it’s the only place where you could qualify for financial help to lower your costs.

Phone: 1-855-805-4325
www.accesshealthct.com

Agile Health Insurance

Agile Health Insurance – offers short-term medical coverage (typically less than 1 year)

Phone: 1-877-353-0962
www.agilehealthinsurance.com

*Connecticut places strict regulations on short-term health plans, and none are for sale in the state as of 2020.

HealthCare.gov

Healthcare Marketplace – visit the Marketplace web site to review the enrollment guidelines and determine which plans are available where you will be living. If you will be living in Connecticut, see Access Health CT (at the top).
Phone: 1-800-318-2596
www.healthcare.gov

United Healthcare – offers short-term medical coverage (typically less than 1 year)

Phone: 1-800-273-8115
www.uhone.com

*Connecticut places strict regulations on short-term health plans, and none are for sale in the state as of 2020.

Please Note:

This list is purely informational. Yale Health provides it as a courtesy and does not endorse the organizations or the coverage provided.

Questions? Please contact Yale Health Member Services at 203-432-0246.