HEALTH INSURANCE FOR ENTREPRENEURS

A Buyer's Guide for the Self-employed and Small Business Owners

eHealth®

HEALTH INSURANCE
FOR THE SELF-EMPLOYED & SMALL BUSINES OWNERS

Building a successful business is hard work. Finding the affordable, quality health insurance you need doesn't have to be. Whether you're self-employed and working out of your garage or the owner of a small business with multiple employees, you face special challenges when it comes to finding and getting health coverage. The purpose of this buyer's guide is to help answer your questions, assess your needs, and provide you with the right tools to find the best health insurance solution for you.

What's Inside

HOW TO USE THIS GUIDE

Different people have different health insurance needs, and those needs can change over time. The needs of self-employed persons may differ from those who own and operate small businesses with multiple employees – but today's self-employed person may be tomorrow's small business owner. With these differences in mind, this guide begins and ends by providing guidance and answering questions relevant for both self-employed persons and small business owners. In between, however, we've created segments specially crafted to address the particular needs of each group.

THE BASICS

We'll start by discussing the value of health insurance, the types of products to consider, and the key concepts and terms that both self-employed persons and small business owners should be familiar with. We'll also discuss some of the specific provisions of the Affordable Care Act (also called the "ACA" or "Obamacare") and what they mean for self-employed persons and small business owners today.

SELF-EMPLOYED

Next, we'll look at the challenges and choices facing self-employed persons, that is, persons in business for themselves or working on a consultant basis, without employees. We'll explain, step by step, how self-employed person's can find and purchase the best health plan for their needs.

SMALL BUSINESS

In the following section, we'll discuss the special challenges and choices facing small business owners with 1-25 employees. We'll walk you step by step through the process to learn how small business owners can find and purchase the best health plan for their needs.

RESOURCES

In the final section, designed for both self-employed persons and small business owners, we'll provide a glossary of additional health insurance terms, as well as references to other valuable health insurance resources.

THE BASICS

STEP 1 — **Health Insurance = Triple Protection**

STEP 2 — **Key Concepts and Terms**

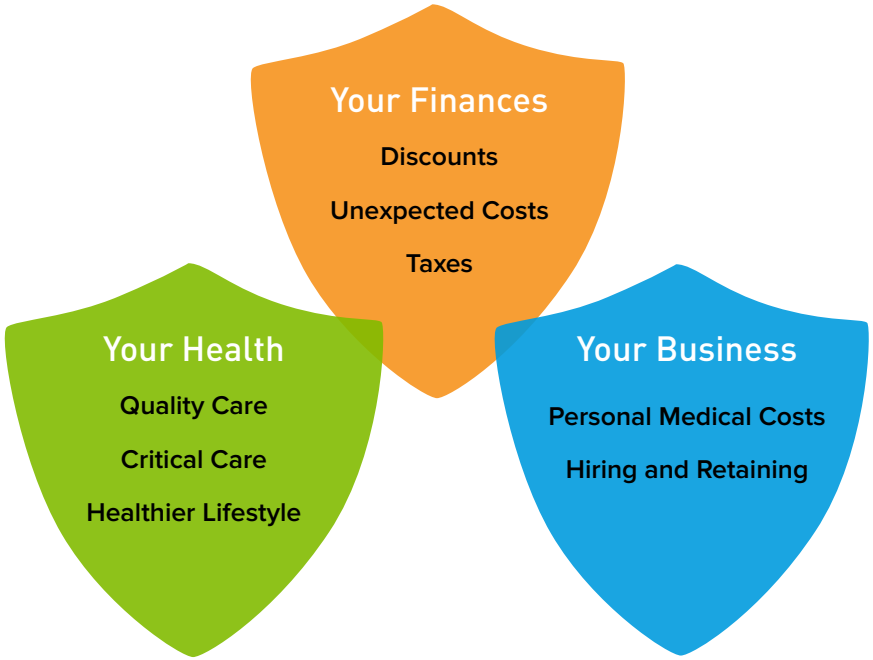
STEP 3 — **Know the Lingo**

STEP 4 — **Health Reform**

Step 1: Triple Protection

The Value of Health Insurance

In order to make a smart health insurance buying decision it helps to understand the value of health insurance and why you need it. It may sound obvious, but many people don't properly understand the basic purpose of health insurance or how it works. In brief, health insurance helps protect self-employed persons and small business owners in the following ways:



1. Health Insurance protects your finances

It entitles you to discounted rates for medical care: Insurance companies negotiate rates with health care providers. Without coverage, the fee charged for a regular office visit can be much higher, possibly twice as high in some cases.

It shields you from unexpected medical costs: Even if your health plan requires you to pay certain costs out of pocket, being covered can help save you from bankruptcy in case of injury or hospitalization.

It can protect you from ACA tax penalties: So long as you maintain qualifying coverage without an unpermitted gap (generally a single gap of up to two months in a year is permitted), you should not face an Obamacare tax penalty.

2. Health insurance protects your health

It improves your access to quality care: As a member of a health insurance plan, you have access to a network of health care providers.

It provides you with critical care: When you're insured you have better access to care for medical emergencies and chronic conditions.

It encourages a healthier lifestyle: You may be more likely to take advantage of regular checkups and preventive care if you know it won't cost you an arm and a leg.

3. Health insurance can help protect your business too

It shields your business from personal medical costs: As a self-employed person or small business owner, unexpected personal medical expenses can cripple your ability to run your business. By limiting your personal liability for medical costs, health insurance can help keep your business afloat.

It helps you hire and retain the best workers: Employer sponsored group health insurance coverage is a valuable enticement in a total compensation package.

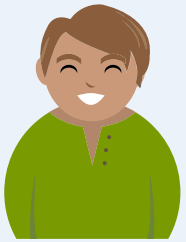
Step 2: Key Concepts and Terms

Comparing Individual & Family and Small Business Plans

There are two primary categories of health insurance for small business owners and self-employed persons to choose from: 1) Individual & Family or 2) Small Business/Group health insurance. Almost everyone can apply for Individual & Family insurance, and depending on the number of employees you have and the regulations in your state, you may qualify for Small Business/Group insurance. In some states, self-employed persons without any additional employees may only be eligible to apply for Individual & Family coverage.

SMALL BUSINESS/ GROUP INSURANCE	VS.	INDIVIDUAL & FAMILY INSURANCE
Yes	Provides coverage for self and family	Yes
Yes	Provides coverage for employees	No
Yes	May have to qualify as business in your state in order to purchase	No
Yes	Subsidies or tax incentives available in some cases	Yes

Individual and Family Plans



These are health insurance plans purchased by individuals to cover themselves or their families. Almost anyone can purchase an individual or family health insurance plan, and it's no longer possible to be declined based on your medical history. You generally need to enroll during the Obamacare annual open enrollment period, which typically runs from November 1 through January 31. Outside of open enrollment, you may only be able to enroll after you've experienced a qualifying life event such as marriage or divorce, the birth or adoption of a child, the loss of coverage, or moving to a new coverage area. Government subsidies may be available to help qualifying persons cover their monthly health insurance premiums.

Small Business/Group Plans

Sometimes referred to as "small business plans" or "group health insurance," this is employer sponsored health coverage. Costs are typically shared between the employer and the employee, and coverage may also be extended to dependents. In certain states, self-employed persons without other employees may also qualify for small business/group plans. There may be special tax incentives available to some businesses providing group coverage to employees..

Top Four Health Plan Types

Whether you're looking at individual and family or small business/group health insurance, there are several different types of health plans available. Some are designed to provide you with as many choices as possible when it comes to doctors and hospitals. Others are designed to keep costs in check by limiting you to a set group of "preferred" doctors and hospitals. Which type is best for you will depend on how much convenience and protection you want, and how much you are willing to spend. Here's a brief review of four popular types of health insurance plan:

HMO

HMO stands for "Health Maintenance Organization." HMO plans offer a wide range of health care services through a network of providers that contract with the HMO, or who agree to provide services to members. Members of HMO plans will typically need to select a primary care physician ("PCP") to provide most of their health care and refer them on to HMO specialists as needed. Health care services obtained outside of the HMO are typically not covered, except in an emergency.

An HMO plan may be right for you if:

- You're willing to play by the rules and coordinate your care through a primary care physician
- You want to save every dollar possible; many HMO plans typically have lower monthly premiums than comparable

PPO

PPO stands for "Preferred Provider Organization." Like the name implies, persons covered under a PPO plan generally need to get their medical care from doctors or hospitals on the insurance company's list of preferred providers in order for claims to be paid at the highest level. It's your responsibility to make sure that the health care providers you visit participate in the PPO. Services rendered by out-of-network providers may not be covered or may be paid at a lower level.

A PPO plan may be right for you if:

- Your favorite doctor already participates in the network; you can sort for plans accepted by your doctor after getting quotes at **eHealth.com**
- You want some freedom to direct your own health care but don't mind working within a list of preferred providers

EPO

EPO stands for "Exclusive Provider Organization." EPO plans are similar to PPO plans but may be somewhat more restrictive when it comes to your network of doctors and hospitals. EPO plans typically do not provide you with coverage outside your network, except in emergencies. EPO plans are becoming more popular with health insurance shoppers, and health insurance companies are offering more of them as well. You're generally not required to select a single primary care doctor with an EPO plan.

An EPO plan may be right for you if:

- You don't mind getting your care through a specific network of doctors and medical providers
- You prefer not to coordinate your medical care through a primary care doctor

HSA

HSA plans are usually PPO plans with higher deductibles, designed especially for use with Health Savings Accounts ("HSAs"). Similar to a flexible spending account (FSA) or 401(k), an HSA is a special bank account that allows participants to save money –pre-tax– to be used specifically for medical expenses in the future. Unlike FSAs, the money in an HSA rolls over every year and can also earn interest. By pairing a qualifying high-deductible health plan with an HSA, participants can save money on health care and earn a tax write-off. Find more information about HSAs online at **www.eHealth.com/hsa.**

An HSA-eligible plan may be right for you if:

- You would like to pay for health care expenses with pre-tax dollars (up to an annual limit)
- You're relatively young and healthy and don't often visit the doctor
- You prefer a cheaper monthly premium even if it means having a higher deductible in case of unexpected injury or illness

Step 3:
Know the Lingo

Five Health Insurance Terms You Must Know

When shopping for a new plan, one of the main challenges people face is understanding health insurance terminology. You'll find a glossary of health insurance terms in the Resources section of this document, and a larger one online at **www.eHealth.com.** But before you proceed, here are five key health insurance terms you should understand:

"Premium"

Your premium is the amount you pay to the health insurance company each month to maintain your coverage. When trying to understand the cost of a health insurance plan, the premium is the first thing to consider. But make sure to balance it against other costs, such as copayments, deductibles and coinsurance.

A good rule:
Choose a lower premium/higher deductible plan if you are relatively healthy and want to save money upfront. Choose a higher monthly premium/lower deductible plan if you want lower costs when you actually get medical services.

"Copayment"

Your copayment, or "copay," is the specific dollar amount you may be required to pay up front for a specific type of medical service. For example, your health insurance plan may require a $25 copayment for an office visit or brandname prescription drug, after which the insurance company may pay the remainder of the charges.

A good rule:
If you make frequent doctor's office visits, make sure you choose a plan with an affordable and consistent copayment.

"Deductible"

Your annual deductible is the amount you may be required to pay out of pocket before the insurance company will begin paying for your covered medical claims. Keep in mind, your monthly premiums and copayments will often not count toward your deductible. Not all plans require a deductible, but choosing a plan with a higher deductible can keep your monthly premiums lower.

A good rule:
Keep your deductible to no more than 5% of your gross annual income if possible.

"Maximum Out-of-pocket Cost"

Pay attention to this amount when considering a new health plan. Your maximum out-of-pocket cost sets a limit to your annual financial liability. Once you have paid out of pocket (typically through deductibles, copayments or coinsurance) to the "maximum" amount, the insurance company pays the full charges for any additional covered medical services rendered that year. Your monthly premium will not count toward your maximum out-of-pocket costs.

"Coinsurance"

Coinsurance is the amount that you may be obliged to pay for covered medical services after you've satisfied any copayment or deductible required by your health insurance plan. Think about it this way: the insurance company may limit coverage for certain services to, say, 80% of charges. So, for example, if your insurance benefits cover 80% of x-ray charges, you will need to pay the remaining 20%, even if your annual deductible is already met. That 20% is considered coinsurance.

Step 4:
What Health Reform Means For You

Understanding the Affordable Care Act

Not all self-employed persons and small businesses are affected by health reform in the same way. The law draws a sharp division between businesses with the equivalent (based on total hours worked) of 50 or more full-time employees and those with fewer than 50 employees.

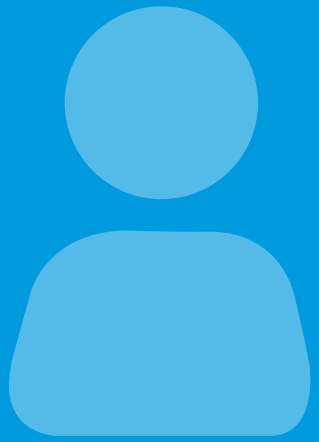
Businesses that employ the equivalent of 50 or more full-time workers will be required to provide group health insurance coverage to their employees or face financial penalties. Small businesses with fewer than the equivalent of 50 full-time workers are generally not required to provide group health insurance coverage, though tax incentives may be available to some who do. Individuals who do not receive group health insurance coverage through an employer-based plan are generally required to purchase coverage on their own or face possible tax penalties.

Are you required to have coverage or provide it to your employees?

	Must have Obamacare compliant coverage or face possible tax penalties	Must provide group health insurance coverage to employees or face possible tax penalities
Small business owners with 50+ full-time employees	✓	✓
Small business owners with fewer than 50 full-time employees	✓	✗
Anyone without employer-based health insurance	✓	✗

* This table provides basic guidance but some exceptions may apply. For example, some people without employer-based coverage are not required to buy coverage on their own, depending on their income or the cost of coverage in their area.

SELF-EMPLOYED



SELF-EMPLOYED PERSONS AND HEALTH INSURANCE

Self-employed persons are those in business for themselves, usually without employees. Many work out of their own homes. Some are consultants, graphic designers, Web engineers or bloggers.

If you're a self-employed person, this section of our guide will lead you through a four step process designed to help you find the coverage that best meets your needs, and to help you manage your coverage effectively once you've purchased it.

Since self-employed persons typically purchase individual and family health insurance coverage rather than small business group coverage, that's what this portion of the guide will focus on. If you want to learn about purchasing group coverage for yourself and your employees, please skip ahead to the small business health insurance section.

STEP 1	STEP 2	STEP 3	STEP 4
Assess Your Needs	**Compare Your Options**	**Apply for Coverage**	**After You Buy**

Step 1: Assessing Your Needs

Understanding Your Needs

Selecting the best health insurance plan for your needs means making an informed choice and knowing your personal priorities. Is budget most important? Which benefits do you really need? Consider the following questions.

"Who will be covered under this plan?"

Why it matters: You probably want to cover yourself and your dependents. But ask yourself: does anyone in your family have other coverage options? In some cases, you may actually be able to save money by covering different members of your family separately under two or more plans.

"Do you maintain a significant savings cushion or do you live paycheck to paycheck?"

Why it matters: If you don't maintain a cushion of funds in the bank, you may want a health plan with a lower deductible. If you do keep a savings cushion large enough to afford a higher deductible, you may be able to find a plan with lower monthly premiums.

"How often did you visit the doctor last year?"

Why it matters: If you visit regularly, it may make sense to pay a higher monthly premium in order to keep your office visit co-payment and deductible low. If you rarely visit the doctor, a plan with higher copayments may cost less per month.

"How much did you spend on health care last year?"

Why it matters: It's important to know what you spend on healthcare and if you expect to spend at the same pace. If these are recurring costs (for prescription drugs, for example) make sure that the plan you select covers these services at a level that's affordable for you.

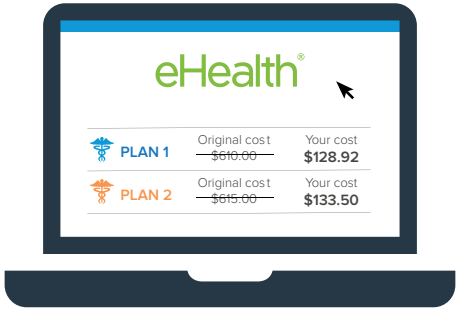
"Are you eligible for group health insurance coverage?"

Why it matters: In most states, self-employed persons buying health insurance plans on their own need to purchase individual and family plans. However, some states may allow persons with business licenses to purchase small business/group plans, even without employees. A small business/group plan may be a more affordable option than individual and family plans in some cases. To learn more about group health insurance, skip to the "Small Business Owner" section of this guide. Find out if you qualify for group health insurance by contacting your state Department of Insurance.

"Are any specific benefits necessary or irrelevant?"

If you're a regular user of prescription medication, make sure you find a plan that covers prescriptions at a co-payment level you can afford. If it's possible you or your spouse could become pregnant, pay close attention to how much you would need to spend form your own pocket for maternity care.

Step 2: Comparing Your Options



Getting Quotes and Researching Your Options

Before you can compare your Individual and Family health insurance options you'll need to know what your choices really are. If you want to save money and make the most of your health insurance dollars, you'll need the broadest possible view of the health plans available. By working with an authorized online marketplace like eHealth you can save time and get a selection of quotes from top insurance companies in your area.

eHealth makes it easy to find the right health insurance plan for your needs and budget. Unlike many other online services, eHealth won't require you to provide lots of sensitive personal information before getting your quotes.

Just go to eHealth.com, enter your zip code and your age, gender, birth date, and smoking status to get:

- **Personalized quotes** from a broad selection of top insurers
- **Side-by-side comparisons** of plan rates and benefits
- **Special online tools** that show you which plans are accepted by your preferred doctor and which plan could save you most on your prescription drugs
- **Personal, unbiased help from licensed agents and representatives** by phone, email, or online chat

Five key criteria to help guide your decision:

You may find an almost overwhelming selection of health insurance companies and plans to choose from. Consider the following five criteria to help you determine which plans best match your personal needs.

1. **Health Benefits:** Which plans provide the must-have benefits you've identified at a level that's affordable for you?

2. **Costs:** Which plans fall within your budget when it comes to premium, deductible, co-payments and coinsurance? Consider an HSA–eligible high deductible plan if your primary requirement is a low monthly premium and the opportunity to save money when paying for medical care.

3. **Physician Network:** Do you have a favorite doctor you want to keep? Which plans does he or she accept? At eHealth.com, you can use our tools to see only those plans that are accepted by your doctor.

4. **Prescription drug coverage:** Not all drugs are covered by all plans, the coverage can vary from one plan to another. eHealth can show you which plan will save you most on your prescription drugs.

5. **Brand:** Are there brand-name insurers that you prefer? Are there any you want to avoid? If you're reviewing your health insurance options on eHealth.com, you can sort the plans you're shown by numerous different criteria to help you narrow your search.

If you're still not sure which plan is going to best meet your needs, please contact a licensed agent for assistance. eHealth's own licensed agents and representatives can be reached by phone, email or online chat.

Step 3: Applying for Coverage

The Enrollment Process

Once you've selected the health insurance plan you'd like, you're ready to enroll. Enrolling in coverage is pretty easy, but here are some things you should know:

Open Enrollment Season

Under the Affordable Care Act, there's an annual open enrollment period during which almost anyone can apply for coverage through an individual or family health insurance plan. The nationwide open enrollment period typically runs from November 1 through January 31. Coverage under a new plan selected during open enrollment generally begins no sooner than the first of the year. Outside of the open enrollment period, you may only be able to purchase Obamacare-compliant health insurance coverage when you experience a qualifying life event. Read on to learn more.

Special Enrollment Periods

Outside of open enrollment, you may trigger a personal special enrollment period of **sixty days** (typically) if you experience what the law considers a **qualifying life event.** These may include things like marriage or divorce, the birth or adoption of a child, the loss of employer-based health insurance, a move to a new coverage area where your old plan no longer works, or a major change to your income.

Health Insurance Subsidies

Qualifying persons with a taxable household income of no more than 400% of the federal poverty level may qualify for government subsidies to make their monthly premiums more affordable. These subsidies, sometimes called advanced premium tax credits, are not available for small business health insurance, only individual and family coverage.

Where to Enroll

You can enroll in a new individual and family health insurance plan through various places including private online marketplaces like eHealth.com, government-run exchanges, or directly through the health insurance company. Working with a private online marketplace may provide you with a broader view of your options and make it easy to get personal advice and help from licensed agents.

What to Expect

You may receive confirmation of your approval for coverage right away, or within a few days. In some cases, it may take longer. Remember that your coverage typically will not begin right after approval. If you enroll by the 15th day of the month, your coverage will generally begin on the first day of the next month. If you enroll after the 15th, your coverage typically won't begin until the first day of the month after next.

Step 4: After You Buy

After Purchasing a Plan

Once you're approved for coverage you will receive official correspondence from the insurance company confirming the date on which your coverage will begin. After that date, you are welcome to begin enjoying your benefits. Look over any documents sent to you by the insurance company and contact their customer service department or your agent with any questions.

Questions about Your Claims

If you have questions or concerns about how a medical claim was processed, your first step is to contact the health insurance company's customer service department.

If they are unable to assist you or you feel that they're not addressing your concerns, contact your health insurance agent for help (if you worked with one). Because of his or her relationship with the health insurance company, your agent can help you understand how your benefits work and may be able to suggest ways to clear up billing disputes.

Adding and Removing Dependents

Family changes such as marriage, the birth or adoption of a child, or an older child's 26th birthday may mean that you need to make changes to the list of persons covered by your health insurance plan. Contact your health insurance company for instructions on how to do so.

Changes to Monthly Premiums and Benefits

Depending on how long you keep your new coverage, you may find that the insurance company occasionally changes the monthly premium you pay for your coverage. They may also make changes to how benefits are covered or paid. Be sure to read through the updates provided by your insurance company and contact their customer service department or your agent for more information.

An Annual Health Insurance Checkup

eHealth recommends health insurance policy holders take a fresh look at their medical coverage during open enrollment to make sure they still have the right plan for their needs and budget. To give your health insurance coverage a check-up, ask yourself the following questions:

"Am I paying too much for coverage?"

If you're healthy and had few or no health insurance claims in the past year, you may be able to reduce your monthly premiums by switching to a plan with a higher deductible. If you do switch to a higher deductible plan, be sure you can afford that deductible in case of an accident or unexpected illness.

"Does my current plan cover the services I need?"

If you find that you're paying too much out of pocket for recurring medical services or prescription drugs, you may want to consider a plan that covers these at a higher level, even if your monthly premium increases.

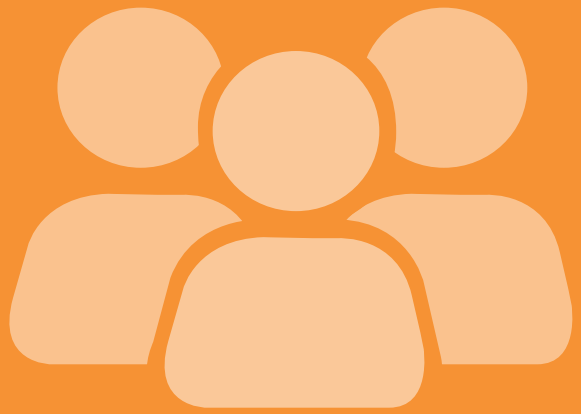
"Have I experienced any big life changes?"

If you were recently married or divorced, had a child, or gained or lost income -- or if you anticipate these things happening in the year to come -- it may be time to reconsider your health insurance options. Take a look at quotes from other health insurance companies in your area to make sure you're not paying too much.

"Do I have access the doctors I want to see?"

If you'd like to be seen by a specific doctor or hospital not covered by your current plan, eHealth.com can help you find out which health plans that doctor or hospital accepts. If you're on an HMO plan and want to be able to see a specialist without a referral, you may want to consider a different type of coverage -- like a PPO or EPO plan, for example.

SMALL BUSINESS



SMALL BUSINESS AND HEALTH INSURANCE

If you're a small business owner with at least one full-time employee other than yourself, this portion of our guide is designed to help you understand your health insurance choices and find the right match for your personal needs and budget. While many of your choices will be the same as those faced by self-employed persons, small business owners often have special concerns and special opportunities. For example, did you know that the money you spend on health insurance for your employees may be tax-deductible?

As you read on, our guide will lead you through a four-step process designed to help you find the coverage you need, and to manage your policy effectively once you've purchased it.

This portion of our guide is primarily concerned with small business/group health insurance plans. If you are not able to purchase a plan that provides coverage to your employees, but only for yourself and your family, please refer to the portion of our guide directed primarily to self-employed persons.

STEP 1	STEP 2	STEP 3	STEP 4
Assess Your Needs	**Compare Your Options**	**Apply for Coverage**	**After You Buy**

Step 1: Assessing Your Needs

Selecting the best health insurance plan for yourself and your business means making an informed choice and knowing your own priorities, and those of your employees. Is cost your number one concern? What kind of coverage is most valuable to you and your employees? Consider the following questions and discuss some of them with your employees to help you gauge your overall needs.

Four questions to help you assess your needs:

"Who will be covered under this plan?"

Why it matters: If you're looking for a plan that will cover yourself and your family as well as employees and their dependents, then you want to make sure you find a group plan with coverage that is affordable for everyone involved and suits the diverse medical and financial needs of those it will cover.

See if any of your employees are interested in joining your plan - they may already have coverage through spouses or other family members. In many cases, there will be a requirement that a minimum number or percentage of employees participate in a plan.

"How much cost-sharing can you afford?"

Why it matters: Group health insurance is employer-sponsored coverage, but monthly premiums are typically paid for by both the employer and employees. In most states, employers are generally required to cover at least 50% of the monthly premium for their employees. Keep this in mind when considering quotes for health plans later in the shopping process.

"Would employees rather pay more up front and less when sick, or vice versa?"

Why it matters: You may wish to discuss this question with your employees. Oftentimes, plans with less expensive monthly premiums come with higher annual deductibles and plans with lower deductibles often come with higher monthly premiums.

If you and your employees don't visit the doctor often, it may make sense to get a plan with a higher deductible (so long as the deductible is affordable in case of an emergency). It's important to find a balance of monthly premium and deductible that works for as many people in your group as possible.

"What kinds of benefits are most important to you and your employees?"

Why it matters: This is another question it may be helpful to discuss with your employees. While federal privacy laws prevent you from asking your employees for information about their personal medical histories, you may still ask them about which kinds of benefits they consider most valuable.

Are they more interested in catastrophic coverage in case of serious illness or hospitalization, or in low deductibles or copayments? How important are benefits covering vision care or dental care? Understanding the benefits most valued by your employees can help you find a plan more likely to meet everyone's needs.

Step 2: Comparing Your Options

Get Quotes

If you want to save money and make the most of your health insurance dollars you'll need the broadest possible view of the health plans available. By working with a licensed agent like eHealth you can save time and get a selection of quotes from top insurance companies in your area.

Get free quotes and personal advice from eHealth
eHealth is licensed to sell health insurance in all 50 states plus DC and we have years of experience matching small businesses with the group health insurance plans best suited to their needs. eHealth makes it easy to find the right health insurance plan for your needs and budget.

Visit us online at **eHealth.com** to learn more about your options.

When you shop with eHealth you'll get:

- **Personalized quotes** from a broad selection of brand-name insurance companies
- **Helpful comparisons** of plan rates and benefits
- **Personal unbiased help from licensed agents and representatives** by phone, email, or online chat
- **Ongoing support at no extra cost** after you buy to help you manage your policy and advise you on dealing with the insurance company

Five key criteria to help guide your decision

When considering your options, use the following five criteria to help you determine which plans best match your needs:

Monthly Premiums | Deductibles, Copayments, Coinsurance | Medical Provider Networks | Precription Drug Coverage | Coverage Add-ons

1. **Monthly premiums:** Know what you and your employees will be required to pay on a monthly basis to maintain your coverage. You'll also want to know what you and your employees may be required to pay toward the monthly premiums of dependent spouses or children.

2. **Deductibles, copayments and coinsurance:** These forms of cost-sharing only come into play when you receive medical care. Make sure they're affordable for you and your employees, both for regular medical care as well as care for more serious or unexpected medical conditions.

3. **Medical provider networks:** If you have a preferred doctor or hospital, make sure they're in-network for any plan you're considering. Otherwise you're claims may be denied or paid at a lower level. eHealth has tools to see which plans your doctor accepts.

4. **Prescription drug coverage:** Some plans cover different prescription drugs than others, or pay more toward them. eHealth has a prescription drug coverage comparison tool that can show you what you're estimated to pay based on your personal Rx needs.

5. **Coverage add-ons:** Health insurance plans typically don't cover dental or vision care. At **eHealth.com** you can add these to your purchase to build a total benefits package for yourself and your employees.

When shopping for a group health insurance plan, eHealth highly recommends that you speak with a licensed agent for personal assistance. eHealth's own licensed agents and representatives can be reached by phone, email or online chat.

Step 3: Applying for Coverage

The Application Process

Completing Your Application

Once you've selected a health insurance plan that you'd like to apply for, your agent can help you through the application process. Be sure to answer all questions honestly to the best of your knowledge. You may find that you'll need to confirm the zip codes and dates of birth of your employees.

Don't Worry – You Won't Be Declined For Medical History

Although the overall health of the persons to be covered under your plan may have some effect on your monthly premiums, no individual in the group will be declined coverage based on his or her medical history. If you legally qualify as a business in your state, you are automatically eligible for the plan you selected. Even if they have a pre-existing medical condition, eligible employees will not be declined for coverage.

Enrollment

Enrollment is the process of getting your employees and their dependents signed up for your new health plan. Your health insurance agent or broker can help you make sure that all the proper materials are collected and provided to the health insurance company so everyone gets enrolled. When you work with eHealth as your agent, a representative can help walk you through the process.

Step 4: After You Buy

After Purchasing a Plan

Once you're approved for coverage you will receive official correspondence from the insurance company confirming the date on which your coverage will begin. After that date, and once enrollment is complete, you are welcome to begin enjoying your benefits. Look over any documents sent to you by the insurance company and contact their customer service department or your agent with any questions.

1. Questions about Claims

If you or your employees have questions or concerns about how a medical claim was processed, your first step is to contact the health insurance company's customer service department.

If they are unable to assist you or you feel that they're not addressing your concerns, you may contact your health insurance agent for help. Because of his or her relationship with the health insurance company, your agent can help you understand how your benefits work and suggest ways to clear up billing disputes.

2. Adding and Removing Covered Persons

Employees may come and go, and they may need to add or remove dependents from time to time. As such, you will periodically need to make changes to the list of persons covered by your group health insurance policy.

Your health insurance agent is available to help you with all these changes in a timely and effective manner.

3. Changes to Monthly Premiums and Benefits

Depending on how long you keep your new coverage, you may find that the insurance company occasionally changes the monthly premium you pay for your coverage. This typically happens once a year during the "open enrollment" period.

They may also change your coverage levels, deductibles, or copayments. Be sure to read through the updates provided by your insurance company and contact their customer service department or your agent for more information.

Step 4: After You Buy Continued

Open Enrollment

With group health insurance, employers are typically committed to a specific plan for one year. When that anniversary approaches, you'll enter your open enrollment period. eHealth recommends that you take a fresh look at your medical coverage once a year, prior to your open enrollment period, to make sure you still have the right plan for your needs and budget. To give your health insurance coverage a check-up, ask yourself the following questions:

"Am I paying too much for coverage?"

Get fresh health insurance quotes at least once a year to make sure you're not paying more than you need to. A licensed broker like eHealth will often contact you when open enrollment approaches around to make sure you still have the right coverage, and to offer you fresh quotes.

"Does our current plan cover the services we need?"

If you and your employees rarely receive medical care, you may be able to find a plan with a lower monthly premium. On the other hand, if you or your employees find that you're paying too much out of pocket for recurring medical services, you may want to consider a plan that covers these at a higher level.

"Has the size of our business changed substantially?"

If your business grew a lot in the past year and you've added new employees, you may find that a single health insurance option isn't going to meet the needs of everyone involved. As they grow, many small businesses offer second or third health insurance options for employees to choose from.

RESOURCES

FOR MORE INFORMATION . . .

We hope this guide has provided you with valuable information and helped you understand your options when it comes to purchasing health insurance for yourself or your small business. Of course, everyone's needs are different, and this guide is not intended to answer every possible health insurance question. Below is a list of additional resources you can turn to for answers.

For more information about your health insurance options:

- Visit eHealth.com to get quotes, compare plans, and enroll in the health insurance plan that's right for yourself, your family, and your employees

- Visit eHealth's Customer Resource Center at **resources.ehealthinsurance.com** to read articles and learn more about what's new in the health insurance market and how to find the best plan for your needs and budget

To learn more about the Affordable Care Act (the health reform law commonly known as "Obamacare"), visit: www.healthcare.gov

Glossary of Insurance Terms

Below is a selection of common health insurance terms. Please note that the definitions offered are meant to provide general guidance only and that some of these terms may be employed in different ways by different insurers. Work with your insurer or licensed agent to make sure you understand the terms used in your own health insurance policy.

Affordable Care Act (ACA): More commonly referred to as "Obamacare," this is the health reform legislation signed into law by President Obamacare in 2010. Major provisions of the law came into effect in 2014. The Affordable Care Act was responsible for reshaping the individual and family health insurance market in the United States, but has had significantly less effect on employer-sponsored health insurance coverage. This law and related regulations may change significantly based on political developments.

Agent: A licensed agent is a person approved by the state to sell health insurance. An agent works to match applicants with a health insurance company or plan that suits their needs. Agents are paid a commission by the insurance company, but generally represent the applicant rather than the insurance company. It does not cost anything extra to work through an agent. An agent can continue to serve you after you buy, for example, to help you understand and deal with benefit and billing disputes with the insurance company.

Allowable Charge: Also referred to as the 'Allowed Amount,' 'Maximum Allowable' or 'Usual, Customary and Reasonable' (UCR) charge, this is the dollar amount typically considered payment-in-full by an insurance company and its associated network of health care providers. The allowable charge is typically a discounted rate rather than the actual charge.

Ancillary Products: Additional health insurance products (such as vision or dental insurance) that can sometimes be added to a medical insurance plan for an additional fee.

Benefit: Any service (such as an office visit, laboratory test, surgical procedure, etc.) or supply (such as prescription drugs, durable medical equipment, etc.) covered by a health insurance plan in the normal course of a patient's health care.

Benefit Level: The amount a health insurance company agrees to pay for a specific covered benefit.

Benefit Year: The annual cycle in which a health insurance plan operates. At the beginning of your benefit year, the health insurance company may alter plan benefits and update rates. Some benefit years follow the calendar year, renewing in January, whereas others may renew at other times.

COBRA: Shorthand for the Consolidated Budget Reconciliation Act of 1985, COBRA is a federal law allowing eligible employees or their dependents to maintain group health insurance coverage under an employer's health insurance plan at individual expense for up to 18 months.

Claim: A bill for medical services rendered, typically submitted to the insurance company on behalf of a patient by a health care provider.

Coinsurance: The amount you may be obligated to pay for covered medical services after you've paid any co-payment or deductible required by your health insurance plan. Coinsurance is typically expressed as a percentage of the allowable charge for a service rendered by a health care provider. For example, if your insurance company covers 80% of the allowable charge for a specific service, you may be required to cover the remaining 20% as coinsurance.

Copayment: A specific charge your health insurance plan may require that you pay for a specific medical service or supply, also referred to as a 'co-pay.' For example, your health insurance plan may require a $25 copayment for an office visit or brand-name prescription drug, after which the insurance company may pay the remainder of the charges.

Deductible: A specific dollar amount your health insurance company may require that you pay out of pocket each year before your health insurance plan begins to make payments for claims.

Dependent Coverage: Health insurance coverage extended to the spouse and children of the primary insured member. Certain age restrictions on the coverage of adult children may apply.

Drug Formulary: A list of prescription medications selected for coverage under a health insurance plan. Drugs may be included on a drug formulary based upon their efficacy, safety and cost-effectiveness. Insurance companies periodically change this list, so drugs may be added, removed, or covered at different amounts.

Effective Date: The date on which a person's health insurance coverage begins.

Employee Contribution: The portion of the monthly health insurance premium paid by the employee, usually deducted from wages by the employer.

Employer Contribution: The portion of an employee's health insurance premium paid by the employer.

Enrollment: The process through which an approved applicant and his or her dependents or employees are signed up for health insurance coverage.

Explanation of Benefits: A statement sent from the health insurance company to a member listing services that were billed by a health care provider, how those charges were processed, and the total amount of patient responsibility for the claim.

Group Health Insurance: A health insurance plan that provides benefits for employees of a business or members of an organization, as opposed to individual and family health insurance.

HIPAA: Shorthand for the Health Insurance Portability and Accountability Act of 1996, federal legislation mandating specific privacy rules and practices for medical care providers and health insurance companies, designed to streamline industry practices and protect the privacy and identity of health care consumers.

Health Savings Account (HSA): A tax-advantaged savings account designed to be used in conjunction with certain high-deductible health insurance plans to pay for qualifying medical expenses. Contributions may be made to the account on a tax-free basis up to an annual limit. Funds remain in the account from year to year and may be invested at the discretion of the individual owning the account. Interest or investment returns accrue tax-free. Penalties may apply when funds are withdrawn to pay for anything other than qualifying medical expenses.

Individual and Family Health Insurance: Health insurance purchased by an individual or family, independent of any employer group or organization.

Major Medical Insurance: A term designating standard individual and family or group health insurance plans providing benefits for a broad range of health care services, both inpatient and outpatient. This contrasts with other types of insurance, such as short-term health insurance, which have less comprehensive coverage and do not generally meet the requirements of the Affordable Care Act.

Maternity Coverage: Coverage for medical services associated with pregnancy and delivery.

Maximum Out-of-pocket: The maximum amount a member will be required to pay out of pocket in a single benefit year, often including copayments coinsurance and deductibles, but not monthly premiums.

Metal Levels: Under the Affordable Care Act ("Obamacare") all major medical health insurance plans are designated by a specific metal level. The metal level of a plan provides a short-hand guide to the amount of cost-sharing a plan is likely to require. Platinum and Gold plans, for example, tend to cover more of the cost of covered medical services than Bronze of Silver plans, but they also tend to come with higher monthly premiums. Bronze or Silver plans tend to come with lower monthly premiums, but they may require policy holders to pay a larger share of the cost when certain medical services are rendered.

Network Providers: A health care provider (such as a doctor or hospital) who has a contractual relationship with a health insurance company. Among other things, this contractual relationship may establish standards of care, clinical protocols, and allowable charges for specific services. Typically, most plans cover providers in the plan's network at a higher rate than non-network providers. Insurance companies regularly add and remove provders from their network.

Obamacare Tax Penalty: Under the Affordable Care Act, most Americans are required to have major medical health insurance coverage or else to face a tax penalty, unless they qualify for exemption. Generally speaking, enrolling in an individual or family or group health insurance plan will protect you from the Obamacare tax penalty, so long as you do not have a gap in your coverage of more than two consecutive months in the same calendar year.

Out-of-pocket Costs: Health care costs that a patient or enrollee must pay for out of his or her own pocket, often including such costs as coinsurance, deductibles, copayments, etc.

Premium: The total amount paid to the insurance company (usually on a monthly basis) to maintain health insurance coverage.

Preventive Care: Medical care rendered not for a specific complaint but focused on prevention and early-detection of disease. Under the Affordable Care Act, many preventive medical services are provided at no out-of-pocket cost to health insurance enrollees.

Primary Care Physician: Some health insurance plans require a patient to choose a primary care physician. A primary care physician usually serves as a patient's main health care provider and may refer a patient to specialists for additional services.

Provider: A term commonly used by health insurance companies to designate any health care provider, whether a doctor or nurse, hospital or clinic.

Referral: The process by which a patient is authorized by his or her primary care physician to a see a specialist for the diagnosis or treatment of a specific condition.

Schedule C: A federal tax form used to report business income or business losses. A copy of this form may be required when applying for a small business/group health insurance plan.

Schedule K-1: A federal tax form used to report a business partner's share of the income, credits and deductions from a business organized as a partnership. This is submitted to the federal government with the partner's federal tax return. A copy of this form may be required when applying for a small business/group health insurance plan.

Short-term Plans: Temporary health insurance plans that provide limited coverage only. Coverage typically extends for no more than 12 months and benefits are often less comprehensive than those provided by a major medical health insurance plan. Prescription drugs, preventive care, and treatment for pre-existing conditions are usually not covered. Also, a short-term plan does not protect you from the Obamacare tax penalty. Generally, short-term plans provide some temporary coverage while you are waiting for a major medical health insurance plan to start, but short-term plans are not a substitute for major medical health insurance.

Specialist: A doctor who does not serve as a primary care physician but who provides secondary care in a specific medical field.

Standard Industrial Classification (SIC) Code: These are codes used to describe or classify businesses based upon the products or services they provide. When you apply for group health insurance coverage, you may be asked to select an SIC code to describe your business. This code provides the insurance company with information about the kind of work your employees are likely to perform and may be used to help determine a monthly premium.

Subsidies (also known as Advanced Premium Tax Credits): Under the Affordable Care Act, persons purchasing individual or family health insurance coverage on their own may be eligible for government subsidies, based on their income. Generally speaking, persons with a household income of no more than 400% of the federal poverty level may be eligible to apply for government subsidies. These subsidies are not available to persons purchasing or enrolling in employer-sponsored group health insurance plans.

Underwriting: The process by which an insurance company determines how much monthly premiums should be for a group health insurance plan.

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