Take the Guesswork Out of Choosing a Health Insurance Plan

Everything you need to know about buying health insurance on your own

Prudential

Welcome!

We know how confusing buying health insurance can be. Whether you're looking for individual health insurance, on or off the exchanges, or trying to find the right type of Medicare or Medigap plans, it can all feel overwhelming.

We're here to help. First, we created this e-book to walk you through the process, explain the lingo, and provide virtual hand-holding as you make this important decision.

Second, we're pleased to announce that Assurance recently joined the Prudential family of companies. Assurance transforms the buying experience for people seeking health insurance options provided by nationally known insurance companies as well as other financial wellness solutions.

Assurance's software uses a combination of advanced data, science and human expertise to help you find the right insurance products for you and your family based on your budget and medical needs. With Assurance as part of our team, you can make your purchase entirely online or with the help of our agents.

So, relax. We're here to help.

Sincerely,

The Prudential and Assurance Team

Prudential

Getting started

We've divided this e-book into two main sections:
Individual Insurance and Medicare.

So, before you dive in and learn everything you didn't know you needed to know about health insurance, use this table to determine which section is right for you:

	Individual Insurance	Medicare
I am under 65 and do not have health insurance.	●	
I am under 65, but my employer does not offer health insurance.	●	
I am 65 (or will be in three months) or older.		●
I am under 65, but I have end-stage renal disease and require dialysis.		●
I am 65 or older and have insurance through my employer.		●
I am under 65 but have a disability that qualifies me for Social Security.		●

Click here to jump to your section:

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Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit www.prudential.com/personal/health-insurance for more information.

Section 1

Individual Health Insurance

Why do I need health insurance?

You're young.

You're healthy.

You're invincible.

Until you're not.

Consider:

You're driving your son to school when someone hits your car from behind, sending both of you to the hospital.

You're playing soccer, twist to kick the ball, and blow out your knee.

You're clearing snow from your roof, the ladder slips, and the next thing you know you're lying on the ground with a broken leg and a concussion.

You want to get pregnant, or you already are.

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit **www.prudential.com/personal/health-insurance** for more information.

Without insurance, in these scenarios you'd face thousands of dollars in medical bills. And, if you already have a chronic medical condition—even something that can be managed effectively—ignoring it because you can't afford your medications means putting yourself at risk for developing complications.

That's where health insurance comes in. Sure, you pay for coverage, but what you get back is significant. Think of it as money in the bank that you didn't know you needed until, well, you do. And, while that "savings" may not cover all of your medical expenses, it will certainly make the pain of paying far more manageable.

Without medical insurance, you're playing a game of medical roulette.

And don't forget... One more reason to buy health insurance?

If you *do* need health care but you don't have insurance, you'll pay much more. That's because insurance plans negotiate lower rates with hospitals, doctors, and other healthcare providers. So, even if you haven't met your plan's deductible, your out-of-pocket costs will be lower than if you went in uninsured.

For instance, maybe you need an MRI.

Without insurance, you'd pay whatever the facility charged (the average rate is $2,600, but it varies based on the part of your body being scanned).[1] But insurance companies negotiate lower rates, sometimes considerably lower—say, $2,000. With insurance—even if you haven't met your deductible yet—you could pay as little as $500.[2]

Without insurance
you'd pay whatever the facility charged—say, $2,000.

With insurance
even if you haven't met your deductible, you could pay a far lower, negotiated rate—more along the lines of $500.

Choosing a Health Insurance Plan.Coverage details vary by plan. Visit www.prudential.com/personal/health-insurance for more information.

The Affordable Care Act and individual insurance

Before 2010, if you didn't get coverage through work, finding decent individual insurance at an affordable price was really tough. If you had a pre-existing condition, you could count on paying thousands of dollars for a bare-bones policy that probably wouldn't even cover your condition. And that was if you could find a plan that would accept you.

Few policies covered prenatal or maternity care. Even when they did, women could expect to pay an average of 60% more than men for similar policies.[2]

Finally, there was no limit on how much you might have to shell out of your own pocket.

Enter the Affordable Care Act (ACA)

Signed into law in 2010, the ACA included numerous protections for people in the individual health insurance market. For example, it:

- **Capped out-of-pocket expenses.** These are the copayments and co-insurance portions of the medical bills you pay. In 2020, they are limited to $8,200 for an individual plan and $16,400 for a family plan, including the deductible.
- Prevented premiums based on **gender or pre-existing conditions**.
- **Provided income-based subsidies**, or tax credits, to help pay premiums.
- Provided funding for some states to **expand Medicaid coverage** to people without children or who had higher income levels than had previously been allowed.
- Required that insurance plans provide **10 essential benefits**, including prenatal and maternity coverage.
- **Enabled children to remain** on their parents' health insurance plans up to age 26.
- Provided for **no-cost preventive and screening services** like mammograms, birth control and immunizations.

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit www.prudential.com/personal/health-insurance for more information.

Finding an individual health insurance plan

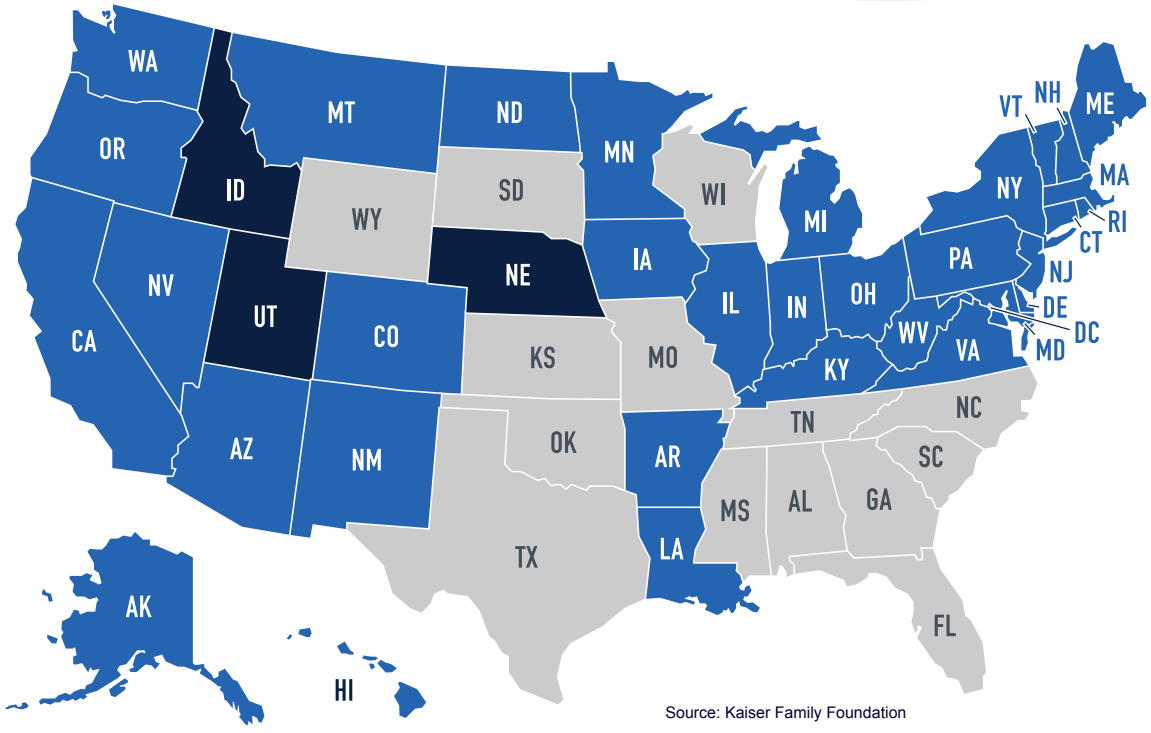
Now that you understand the value of health insurance, you might be wondering how to find an affordable policy. We're here to help!

First, you need to find out two things: Whether you qualify for Medicaid (the state-run health insurance plans for those with low incomes) and whether you qualify for a subsidy, or tax credit, from the federal government if you purchase health insurance on the exchange.

Do I qualify for Medicaid?

It's worth checking to see if you qualify for Medicaid. As of October 2019, 37 states and Washington, D.C., have expanded their Medicaid programs, allowing more people to be covered and increasing the levels of income that qualify. Every state is different, however, so check with yours by calling your state Medicaid office.

You can find out if your state has expanded its program with this **interactive map**.



Source: Kaiser Family Foundation

Adopted and Implemented	●	AK, AR, AZ, CA, CT, CO, DC, DE, HI, IA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MT, ND, NH, NJ, NM, NY, NV, OH, OR, PA, RI, VA, VT, WA, WV
Adopted but Not Implemented	●	ID, NE, UT
Not Adopted	●	AL, FL, GA, KS, MO, MS, NC, OK, SC, SD, TN, TX, WI, WY

Do I qualify for a subsidy?

As part of the ACA, states and the federal government created online portals, called "exchanges," designed to help you choose an insurance plan. **If you qualify for a subsidy** and want to use it, you *must* purchase your health insurance on the exchange. You can do this on your own at healthcare.gov, or have a licensed health insurance broker help you.

If you don't qualify for a subsidy, you can still get insurance on the exchange, or you can shop the open insurance market, where you might have more options.

Most people on the exchanges receive subsidies in the form of federal tax credits to help cover premium costs. If you qualify, you can get the credit ahead of time to help pay your monthly premium, claim it later when you file your tax return, or receive it throughout the year.

The subsidies are based on the number of people in your household (including you) and your estimated income for the year your health coverage starts. To qualify for a subsidy, your income must be from 100% to 400% of the federal poverty level.

A word of warning: Make sure you err on the side of caution when estimating your income. If you get it wrong and earn more than you estimated, you'll have to pay back part or all of the tax credit.

You can see if you qualify for a subsidy—and how much it would cover—using this simple tool.

Keep an eye on the dates

You can only sign up for individual health insurance during the open enrollment period, which typically starts the beginning of November and ends mid-December.

After that, you can only enroll under special circumstances, such as losing other insurance, getting married or having a baby; otherwise, you'll need to wait until the next open enrollment period.

Choosing a Health Insurance Plan.Coverage details vary by plan.
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When to call a professional

Is it all feeling a bit daunting? Don't worry—you won't have to go it alone. **A licensed health insurance agent or broker** can walk you through it all—and it won't cost you a dime. Brokers are trained to find the right health plan for you based on your specific needs, and the plan pays them a commission when you sign up.

When you talk to a broker, let them know:

- Your income, the number of people in your family, your age, the ages of any others you want to cover, and whether you smoke. Your broker can tell you if you qualify for a subsidy on your state's exchange and ensure you get the right price for the right plan.
- How much you're willing to pay out of pocket, including monthly premiums and any deductibles and copayments.
- Identify any healthcare providers, including hospitals, you absolutely *must* have access to.
- Whether you travel a lot. (You might need a plan that provides good coverage when you're out of the coverage area.)
- How you feel about someone else controlling which doctors you can and can't see.
- Any major health conditions, including pregnancy.

You can find a **health insurance broker who knows your local market here**.

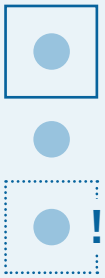
Alphabet soup

When deciding among health insurance plans, it helps to learn the lingo. The two main types of plans on the individual market:

Health maintenance organization (HMO)

This is the most restrictive type of health insurance plan. It typically requires that you see only the providers and use only the facilities in its network (except in emergencies), so it probably doesn't make sense for you if you travel a lot or want to pick and choose your own doctors.

Also, if you want to see a specialist, you'll usually need a referral from your primary care physician.



Preferred provider organization (PPO)

This type of plan is more flexible. Like an HMO, it contracts with doctors, other healthcare providers and facilities—but you're not restricted to using those specific providers.

(You'll pay less if you stay in-network, but you can choose to go out of network at a higher cost.)

Pro tip:
Provider directories are often out of date—even when they're online—so ask your doctor's office if they participate with the plan you want.

Choosing a Health Insurance Plan.Coverage details vary by plan. Visit **www.prudential.com/personal/health-insurance** for more information.

Peeling back the onion: What individual health insurance plans cover

- **Ambulatory patient services** (outpatient care you get without being admitted to a hospital)
- **Emergency services**
- **Hospitalizations** (including surgery and overnight stays)
- **Pregnancy, maternity, and newborn care** (before and after birth)
- **Mental health and substance use disorder services**, including behavioral health treatment (including counseling and psychotherapy)
- **Prescription drugs**
- **Rehabilitative and habilitative services and devices** (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- **Laboratory services**
- **Preventive and wellness services and chronic disease management**
- **Pediatric services, including oral and vision care** (but adult dental and vision coverage aren't essential health benefits)

Note: This list refers only to ACA and other qualified plans, which also must cover birth control and breastfeeding supplies.

In addition, you have access to preventive and wellness services with no out-of-pocket costs when you see a provider within your plan's network.

These include:

- all recommended vaccines for adults and children
- screening mammograms
- cholesterol
- blood pressure
- diabetes
- colorectal cancer screening
- nutritional counseling if you're at risk for certain diseases

Plans must also offer dental coverage for children. Some plans will offer dental for adults and vision coverage for children *and* adults.

You can review the **full list of covered services**.

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit **www.prudential.com/personal/health-insurance** for more information.

Stripping it down: Bare-bones health plans[3]

There is another option on the individual market, but while it can make sense in many cases, proceed with caution: **Short-term health insurance policies** often have very limited coverage, high out of pocket costs, and can only insure you for up to 12 months (shorter policies are also available).

These policies' benefits are so limited, they come with their own warning: *"Check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits..."* What's more, once your coverage ends, you can't sign up for an ACA-compliant policy until the next open enrollment period—no matter what your circumstances.

So, tread carefully and understand the limitations.

What does it cover?

● Yes ✕ No ◑ Inquire with provider

	ACA Compliant	Short-Term Policy
Must cover all pre-existing conditions	●	✕
Provides income-dependent subsidies to make premiums more affordable	●	✕
Limits out-of-pocket expenses	●	✕
Covers all prenatal and maternity services	●	◑
Provides screenings and other wellness services with no out-of-pocket cost	●	✕
Provides 10 essential health benefits	●	◑
Limits the number of doctor visits	✕	◑
Limits the amount it will cover for services like hospital stays	✕	●
Covers prescription drugs	✕	◑
Can set the price of the plan based on your age and ZIP code	✕	●

*Some states prohibit the sale of short-term health insurance policies that lack protections for people with pre-existing conditions.

Choosing a Health Insurance Plan.Coverage details vary by plan. Visit www.prudential.com/personal/health-insurance for more information.

Choosing an individual plan

There are four main types of plans under the ACA: bronze, silver, gold and platinum. All cover the same required benefits.

The major difference is cost, though if you choose the silver plan, you may qualify for cost-sharing reductions that could save you hundreds or even thousands of dollars a year.

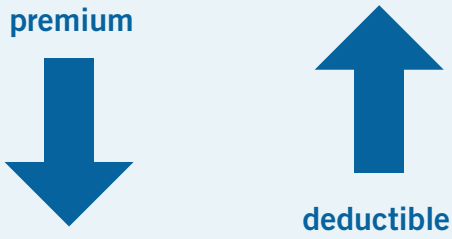
There are three numbers you should think about when deciding on a plan:

1. **The monthly premium.**
This is what the plan actually costs.

2. **The deductible.**
This is the amount you have to pay for medical services before the insurance kicks in (except for preventive services).

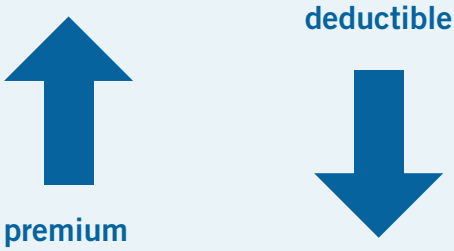
3. **Co-payments and co-insurance.**
This is the amount you have to pay even after you meet your deductible. For instance, you may have a $25 copayment for specialist visits. (Even so, all plans have a maximum out-of-pocket limit. For instance, in 2020, it was $8,150 for individual coverage and $16,300 for family coverage).

Here is the "Golden Rule" when choosing a health plan:



The lower the premium, the higher the deductible and the out-of-pocket limit.

Or, to put it another way:

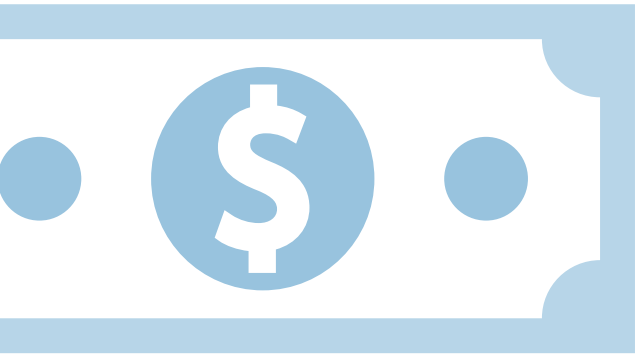


The higher the premium, the lower the deductible and out-of-pocket limit.

So, don't focus only on that monthly payment. Consider how much you spent last year on health care, any medical conditions you and your family have, and any issues you may need treated in the coming year (e.g., a knee replacement).

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit www.prudential.com/personal/health-insurance for more information.

You and your plan: Who pays what*



Plan type	The insurance company pays	You pay
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

*Estimated averages; actual amounts will vary based on where you live and the plans available in your area.

What's a catastrophic plan?

If you go on the exchange and punch in all your info, you may see a fifth type of plan pop up: **catastrophic** coverage. These are available only to people under age 30 or those with a hardship exemption or affordability exemption (i.e., your employer's health insurance is unaffordable).

While the monthly premium is low, you aren't eligible for a subsidy. And the deductibles are very high. For instance, in 2020 it was $8,150 for an individual plan. (Silver lining: once you meet your deductible, there are no other out-of-pocket expenses.) These plans cover the same essential health benefits as other ACA-compliant plans, including certain preventive services, at no cost. They also cover at least three primary care visits per year before you've met your deductible.

Pro tip: Before choosing a catastrophic plan, compare its premium and deductible with bronze or silver plans for which you may be able to get a subsidy.

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit www.prudential.com/personal/health-insurance for more information.

Which plan is right for me?

I'm under 30 and very healthy with no medical costs last year except for a bout with the flu.

Catastrophic

I'm over 30, very healthy and don't take any prescription drugs.

Bronze

I qualify for cost-sharing reductions.

Silver

cost-sharing reductions

I live paycheck to paycheck with very little room for unexpected expenses.

I have high blood pressure and diabetes, but both are well under control.

Gold

I'm pregnant or planning to get pregnant.

I'm being treated for breast cancer.

Platinum

I take several very expensive drugs for multiple sclerosis and wind up in the hospital about once a year.

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit www.prudential.com/personal/health-insurance for more information.

High-deductible plans and health savings accounts (HSAs)

Although no one likes paying high deductibles, there is a silver lining: if you meet a certain cost level (between $1,400 and $6,900 in 2020 for individual coverage and $2,800 and $13,800 for family coverage), you can contribute to a health savings account. Your money goes in before taxes, grows tax free, and withdrawals are tax free as long as you spend the money on approved medical expenses (**see what's allowed**).

For instance, in 2020, you could contribute up to $3,550 a year for an individual policy and $7,100 for family coverage. If you're between the ages of 55 and 65, you can contribute an extra $1,000 each year. The best news: There's no time limit on when you can use the money, so it can continue to earn compound interest (or even grow with investments if your plan allows) until you need it.

You can even use your HSA money once you're eligible for Medicare—though if you enroll in traditional Medicare, you'll have to stop contributing to your account.

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit **www.prudential.com/personal/health-insurance** for more information.

Section 2

Medicare

Medicare

Part A

What it covers — All inpatient care, home health care and skilled nursing facilities.

What it costs — No monthly premium for most people, but has an annual deductible ($1,420 in 2020) and co-insurance.

When you get it — Must sign up in the seven-month period starting *three months before your 65th birthday;* if you sign up for Social Security you are automatically enrolled in Part A.

Part B

What it covers — All outpatient services like doctor visits as well as certain specialty drugs, like those administered in a doctor's office.

What it costs — Monthly premium ($144.30 month in 2020, higher depending on your income) and annual deductible ($197 in 2020). Also copayments or coinsurance.

When you get it — Buying Part B is voluntary, but you may pay a penalty if you don't sign up in the seven-month period starting three months before your 65th birthday (assuming you're not covered under an employer plan).

Part C

What it is — The managed care form of Medicare known as Medicare Advantage; it covers everything—and sometimes more—than traditional Medicare covers.

How it works — Plans may pay all or part of the Part B premium and may or may not charge an additional premium.

What it costs — Premiums and deductibles vary by plan.

When to sign up — Like Part B, Medicare Advantage is voluntary, but you may pay a penalty if you don't sign up in the seven-month period starting three months before your 65th birthday (assuming you're not covered under an employer plan).

Part D

What it covers — Covers most prescription drugs.

What it costs — Premiums vary based on income and the plan you choose. You also have to meet an annual deductible ($435 in 2020).

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit www.prudential.com/personal/health-insurance for more information.

Happy birthday!

When you turn 65 you are eligible for the largest health insurance program in the country: Medicare. If you've already signed up for Social Security, then you're already enrolled in Medicare Part A, which covers hospitalization, durable medical equipment and skilled nursing facilities.

Otherwise, you'll need to sign up for it during the seven-month period that begins three months before you turn 65 plus your birthday month and ends three months after you turn 65. Part A is "free" because you've been paying for it with automatic deductions since you earned your first paycheck.

Part B, which covers outpatient services like doctor visits, does have a monthly premium. If you don't have employer-provided health insurance, you should sign up during that seven-month period. Otherwise, you may have to pay a penalty when you *do* sign up, and your premiums may be higher.

Part B doesn't cover most prescription drugs. For that, you need a separate Part D plan, which also carries a premium and deductible.

Or...
you can skip all that and go for a Medicare Advantage plan, which covers the whole gamut and more.

Confused?
Don't be. We're here to walk you through it.

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit www.prudential.com/personal/health-insurance for more information.

Medicare or Medicare Advantage?

There are two types of Medicare: traditional, or fee-for-service, and Medicare Advantage, the managed care form of Medicare.

No matter which you choose, you still have to sign up for parts A and B.

This table highlights the differences between traditional Medicare and Medicare Advantage:

Medicare	Medicare Advantage
You pay the Part B premium.	You have to pay the Part B premium, but some plans cover some or all of the cost for you.[4]
Can enroll in a Medigap plan to cover out-of-pocket expenses such as cost sharing and deductibles.	Cannot enroll in a Medigap plan. Must pay all out-of-pocket expenses yourself.
Can see any healthcare provider and be treated in any facility that accepts Medicare. Can see nonparticipating providers, but it may cost more.	Must see in-network providers or pay more out of pocket.*
Does not require preauthorization for services.	Most plans require preauthorization for high-cost services such as hospitalization, durable medical equipment, skilled nursing facility stays and specialty drugs.[4]
Requires a separate drug plan (Part D) for prescription drugs, which carries a separate premium and deductible.	Most plans cover outpatient prescription medications.[4]
Does not cover vision, hearing, or dental. (Few Medigap policies cover these items, either.)5	Most plans cover additional services such as vision, hearing, or dental, even gym memberships.4 Some may also pay for services such as grocery deliveries, caregiver support, and retrofitting homes for enrollees with serious medical conditions.
No out-of-pocket annual limit.	Has an out-of-pocket annual limit. For instance, in 2019, the average out-of-pocket limit was $5,059 for in-network services and $8,649 for both in-network and out-of-network services.[4]
Does not allow for health savings accounts.	Some Advantage plans combine a high-deductible insurance plan with a medical savings account you can use to pay for certain healthcare costs.

*Provider directories are often out of date, even when online. Ask your doctor's office if they participate with the plan you want.

Help!

If you still need help choosing a plan, contact your local **State Health Insurance Assistance Program (SHIP)**.

Trained counselors provide free support to Medicare beneficiaries, their families and their caregivers.

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit **www.prudential.com/personal/health-insurance** for more information.

Closing the gap with a Medicare supplemental plan

About one in four Medicare beneficiaries, most in traditional Medicare, spend at least 20% of their incomes on premiums plus medical care.

That's pretty high. Which is why about a third of Medicare beneficiaries also buy a supplemental Medicare plan, otherwise known as Medigap, to cover deductibles, copayments and co-insurance.

Some Medigap plans also provide benefits Medicare doesn't, such as coverage when you travel out of the country. These plans are standardized, governed by state and federal laws, and known by the letters A through D, F, G, K, L, M and N (based on their benefits).

Plans C and F are no longer available to people who were new to Medicare beginning in 2020.

Key points to know about a Medigap plan:

- You must have Part A and Part B Medicare in order to qualify for a Medigap plan.
- You should buy a Medigap plan within 6 months of enrolling in Part B, when the plans have to cover you regardless of any preexisting conditions. After that, they can outright reject you or charge you a far higher premium.
- You can only buy a Medigap plan for yourself. Your spouse/partner must buy their own plan.
- You don't need a separate drug plan if your Medigap plan covers prescription drugs; conversely, if you have a Medicare Part D drug plan you don't need a Medigap plan that covers prescription drugs.
- Only a few states allow Medicare beneficiaries under 65 to purchase Medigap insurance.
- If you are still covered under your employer or a retiree health plan, you don't need Medigap as that other plan will help pay for non-covered Medicare costs.

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit www.prudential.com/personal/health-insurance for more information.

Your rights under Medicare

No matter which plan you choose—traditional Medicare or Medicare Advantage—you have unalienable rights to:

- Be treated with dignity and respect at all times.
- Be protected from discrimination.
- Have your personal and health information kept private.
- Get information in a format and language you understand from Medicare, health care providers, Medicare plans, and Medicare contractors.
- Have questions about Medicare answered.
- Have access to doctors, other health care providers, specialists, and hospitals for medically necessary services.
- Learn about your treatment choices in clear language that you can understand and participate in treatment decisions.
- Get Medicare-covered services in an emergency.
- Get a decision about health care payment, coverage of services, or prescription drug coverage.
- Request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.
- File complaints (sometimes called "grievances"), including complaints about the quality of care.

[1]The Street. How much does an MRI cost. https://www.thestreet.com/lifestyle/health/how-much-does-an-mri-cost-14972340

[2]National Women's Law Center. Turning to Fairness. 2012. Accessed at http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf

[3]Kaiser Family Foundation. ACA Open Enrollment: For Consumers Considering Short-Term Policies. Available at: https://www.kff.org/health-reform/fact-sheet/aca-open-enrollment-for-consumers-considering-short-term-policies/

[4]Kaiser Family Foundation. A Dozen Facts About Medicare Advantage in 2019. Available at: https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/. Accessed October 11, 2019.

[5]Centers for Medicare & Medicaid Services. Medicare & You.

[6]Schoen C, Davis K, Willink A. Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status. The Commonwealth Fund. May 12, 2017. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2017/may/medicare-beneficiaries-high-out-pocket-costs-cost-burdens-income

Next steps to finding the right insurance for you

1. Review this e-book to learn more about your options.
2. Identify your needs.
3. Gather necessary information in one place.
4. For guidance on plan selection and enrollment, visit www.healthplans.prudential.com/health.
5. If you call, ask questions so that you understand what's covered and what's not.

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit www.prudential.com/personal/health-insurance for more information.

Terms to know

Choosing a Health Insurance Plan.Coverage details vary by plan.
Visit **www.prudential.com/personal/health-insurance** for more information.

Glossary

Deductible: What you must pay out of pocket before your health insurer starts paying for your care.

Essential benefits: A set of 10 categories of services health insurance plans must cover under the Affordable Care Act.

Federal poverty level: A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine your eligibility for certain programs and benefits, including savings on marketplace health insurance, and Medicaid coverage.

Hardship or affordability exemption: If you're over age 30, you must meet at least one of these criteria to get catastrophic coverage: being homeless, experiencing the death of a family member or a fire, flood or other natural or human-caused disaster; filing for bankruptcy; having significant medical debt; being ineligible for Medicaid because your state didn't expand eligibility; or having income too low to afford your employer's insurance.

Health insurance broker: An agent or broker is a person or business who can help you apply for help paying for coverage and enroll in a Qualified Health Plan through the Marketplace or on the open market.

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.

Health savings account: A type of savings account that lets you set aside money on a pretax basis to pay for qualified medical expenses.

Medicaid: State-run health plans for low-income people.

Medicare: Federal health insurance program for those 65 and older, those with disabilities, and those with end-stage-renal disease.

Medigap: Medicare supplemental insurance, sold by private companies, that can help pay some health care costs original Medicare doesn't cover, like copayments, coinsurance and deductibles.

Network: Doctors, hospitals and medical facilities that contract with a plan to provide services.

Open enrollment: The annual period when people can enroll in a health insurance plan.

Out-of-pocket: Medical care expenses that aren't reimbursed by insurance. These include deductibles, coinsurance and copayments.

Participating provider: Provider that accepts your health plan's approved amount for services as full payment.

Pre-existing condition: A health problem, like asthma, diabetes or cancer, you had before the date that new health coverage starts. Qualified insurance plans can't refuse to cover treatment for your pre-existing condition or charge you more due to it.

Preferred provider organization (PPO): A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals and providers outside the network for an additional cost.

Premium: The monthly fee you pay for health insurance coverage.

Qualified health plan: An insurance plan that's certified by the Health Insurance Marketplace provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments and out-of-pocket maximum amounts) and meets other requirements under the Affordable Care Act.

Referral: A written order from your primary care doctor for you to see a specialist or get certain medical services, which is required in most health maintenance organizations.

Short-term health insurance: Policy issued for a limited time (typically less than 365 days) to provide major medical coverage. It typically has significant limitations in what it covers and may price the plan—or refuse to cover you—based on pre-existing conditions.

Special enrollment period: A period outside open enrollment during which you can sign up for individual health insurance or Medicare if you meet certain criteria.

Subsidies: Tax credits that lower the cost of health care coverage purchased on a marketplace exchange for those with household incomes between 100% and 400% of the federal poverty level.

Note: Unless otherwise noted, the source for this is www.healthcare.gov

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1040812-00001-00

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