Shopping for Health Insurance

A BUYER'S GUIDE FOR INDIVIDUALS AND FAMILIES

SANFORD HEALTH PLAN

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SECTION 1

THE BASICS

Why is it important to have health insurance? What types of insurance plans are available? What key concepts and terms should you know? All of these questions and more are covered in this section we call the basics. By the end of this guide, you'll feel ready to shop and compare plans and make the best health insurance decisions for you and/or your family.

Why should you have health insurance?

Health insurance protects your health

Health insurance protects your finances

Health insurance protects your future

We're here to help.

With Sanford Health Plan, you receive expertise and guidance from a local insurance agent every step of the way. We can help answer your questions and provide you with a quote for coverage. Call (888) 861-5171 or visit sanfordhealthplan.com/shop-plans today.

As an individual and/or family member, health insurance offers you protection in three essential areas:

1. Health insurance protects your health

With health insurance coverage, you have access to quality care through a network of health care providers. You also have better access to care for medical emergencies and chronic conditions. Additionally, you're more likely to take advantage of regular checkups and preventive care often offered at no cost.

2. Health insurance protects your finances

Health insurance protects you from unexpected medical costs. Even if your plan requires you to pay certain costs out of pocket, coverage can protect you from bankruptcy after an injury or hospitalization.

3. Health insurance protects your future

By maintaining your health, you can pursue passions, thrive in a variety of areas and enjoy life to the fullest. Finding and selecting the right health insurance plan for your budget and lifestyle is an important step in protecting your most valuable asset – your health.

As the old saying goes, an ounce of prevention is worth a pound of cure—and the research bears this out. Maintaining your health can not only help you save on future medical costs but also supports your long-term health.

SECTION 2

KEY CONCEPTS

What is the difference between individual and group health insurance plans?

Individual plans

These are health insurance plans purchased by individuals to cover themselves or their families. Almost anyone can purchase individual health insurance and you can no longer be denied coverage based on medical history. Generally, you need to enroll during the annual open enrollment period, which runs from November 1, 2024 and ends January 15, 2025. Those who sign up during this time have coverage effective January 1 or February 1, 2025.

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 by moving to a new coverage area. Federal assistance may be available to help qualifying members with monthly premium assistance and cost-sharing benefits.

Group health insurance plans

Sometimes referred to as small business plans, group health insurance plans are employer-sponsored health coverage. Costs are typically shared between the employer and the employee, and coverage may also be extended to spouses and dependents. Insurance carriers cannot ask health questions to quote the group or deny coverage based on medical history.

Health Plan Types to Know

There are several different types of networks available. Some are designed to provide you with as many choices as possible. Others are designed to keep costs in check through a more focused network of doctors and hospitals. The best type of network for you depends on how much convenience and protection you want and how much you're willing to spend.

Here's a breakdown of two popular networks.

Broad Network

Under a Broad Network, members generally must receive their medical care from their insurance company's list of preferred providers for claims to be paid at the highest level. It's your responsibility to make sure your health care providers participate in the PPO. You may receive care from an out-of-network provider, but, benefits will be paid at a lower level.

A Broad network may be right for you if:

- You see doctors at multiple health systems.
- You are willing to pay more in premium for broader access to doctors.
- You want out-of-network benefits.

Narrow Network

Narrow Networks offer a wide range of health care services through a network of providers who contract with the health plan at a particular network rate, meaning they agree to provide services to members. Health care services received outside of the narrow network are typically not covered except in an emergency.

A Narrow Network may be right for you if:

- You're willing to coordinate your care through a focused network of doctors and hospitals.
- You want to save every dollar possible. Narrow networks typically have lower monthly premiums compared to broad networks.
- You want to deeper savings on services through better network discounts.

Here's a breakdown of two popular plan types.

Traditional Plans

When enrolled in a traditional health insurance plan, you will be responsible for paying your premium, which is the monthly cost of the health care plan. You may also pay a copay, which is a fixed payment for each time medical services are rendered, such as visiting the doctor or a specialist. The costs and benefits of traditional health insurance plans can vary. Some plans have an annual deductible, which is an out-of-pocket cost that must be paid before the insurance covers any medical bills. Other plans charge coinsurance, which might be 20% of the costs, while the insurance covers the other 80%. Often, there's a maximum out-of-pocket cost, meaning they cap the amount you would have to pay within the plan's year.

Some benefits of a traditional health insurance plan are:

- You prefer to have predictable costs for services with copays for most commonly used services like doctor office visits and prescription drugs.
- This type of plan does not require you to pay as much upfront.

HSA-eligible Plans

HSA-eligible plans are high deductible health plans (HDHPs) designed for use in conjunction with a health savings account (HSA). Similar to a flexible spending account (FSA) or 401(k), this type of savings account allows members to save money on a pre-tax or tax-deductible basis to pay for future medical expenses. Unlike FSAs, the funds in an HSA roll over each year and can earn interest. By pairing an eligible plan with an HSA account, members can save on health care expenses and earn a tax write-off.

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 need frequent doctor visits, or have chronic conditions that cause you to meet your deductible and out-of-pocket maximum each year.
- You prefer a lower monthly premium, even if it means having more cost-sharing in the event of an unexpected injury or illness.

SECTION 3

INSURANCE TERMS TO KNOW

When shopping for health insurance, terminology can be a barrier to fully understanding your options. Below we highlight five key health insurance terms you should get to know as you consider your insurance options.

Premium

A premium is an amount you pay to your 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 you'll want to consider. But make sure to balance it against other costs, such as copayments, deductibles and coinsurance.

Tip: Choose a lower premium/higher deductible plan if you are relatively healthy and want to save money upfront. Choose a higher premium/lower deductible plan if you want lower costs when receiving medical services.

Copayment

A copayment, or copay, is the amount you may be required to pay for a specific type of medical service. For example, your health insurance plan may require a $20 copayment for an office visit or brand-name prescription drug. After you pay this amount, your insurance company will pay the remaining amount.

Tip: If you make frequent doctors' office visits, choose a plan with affordable and consistent copayments.

Deductible

The annual deductible is the amount you may be required to pay out of pocket before your insurance company begins paying for your covered medical claims. Keep in mind, your monthly premiums and copayments will 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.

Tip: If possible, limit your deductible to no more than 5% of your gross annual income.

Coinsurance

Coinsurance is the amount you may be obligated to pay for covered medical services after you've satisfied any copayment or deductible required by your health insurance plan.

Here's an example: Your insurance company may limit coverage for certain services to 80%. If you receive an X-ray and your insurance benefit covers 80% of the cost, you will need to pay the remaining 20% even if your annual deductible is already met. That 20% is considered coinsurance.

Maximum Out-of-pocket Cost

It's important to know your maximum out-of-pocket cost when considering a new health plan. This amount sets a limit on your annual financial liability. Once you have paid out-of-pocket to the maximum amount – typically through deductibles, copayments or coinsurance – your insurance company will pay for any additional covered medical services that year. Your monthly premium will not count toward your maximum out-of-pocket costs.

SECTION 4

If you don't qualify for a Marketplace plan through **marketplace.sanfordhealthplan.com** direct enroll at Sanford Health Plan. Get a quote at **sanfordhealthplan.com/shop-plans** or call **(888) 861-5171 (TTY: 711).**

HOW YOU MAY BE ABLE TO SAVE WITH NEW, LOWER COSTS ON THE FEDERAL MARKETPLACE

With the passing of the American Rescue Plan in March of 2021, changes included new, lowered costs for Marketplace health insurance coverage. You may qualify for lower premiums, even if you've never qualified for discounts on health insurance in the past.

Why is there more access to affordable coverage through the Marketplace?

In response to the COVID-19 pandemic, President Biden signed the American Rescue Plan into law, making more people eligible to receive financial assistance for health care coverage, housing and unemployment, among other relief areas. In 2022, President Biden signed the Inflation Reduction Act into law, which extends those expanded premium tax credits through 2025.

Since April 2021, subsidies have helped people save an additional $50 to $70 on their monthly premium through individual Marketplace coverage, which varies based on income and household size. People can apply for Marketplace coverage if they have a qualifying life event or during the annual open enrollment, which starts November 1, 2024 and ends January 15, 2025. Those who sign up during this time have coverage effective January 1 or February 1, 2025.

How do I know if I qualify?

By applying for individual Marketplace coverage, you can find out if you qualify for more tax credits. This could lower your monthly premium. To apply for coverage, visit **marketplace.sanfordhealthplan.com** or let us connect you to a local agent in your area by calling (888) 861-5171.

Start exploring your options with Sanford Health Plan. Visit sanfordhealthplan.com/get-a-quote to request a quote or call (888) 861-5171 (TTY: 711) to talk with a local agent.

SECTION 5

5 CRITERIA TO USE WHEN SHOPPING FOR A HEALTH INSURANCE PLAN

1. **Monthly premiums:** To maintain your coverage, you'll be required to pay a monthly fee known as your premium. Make sure this amount stays within your budget. You'll also want to know what you may be required to pay toward the monthly premiums of a spouse or dependent covered under your plan.

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 your claims may be denied or paid at a lower level. Sanford Health Plan has tools to see which plans your doctor accepts.

4. **Prescription drug coverage:** Some plans cover different prescription drugs than others, and some plans pay more toward prescription drugs than others. Sanford Health Plan has a prescription drug coverage comparison tool so you can see what you're estimated to pay based on your prescription needs.

5. **Member perks and discounts:** At Sanford Health Plan, we go beyond health insurance coverage by giving our members access to a variety of discounts from local and national retailers on products and services in a variety of categories. We also offer virtual care at no cost under certain plans and monthly gym reimbursements at participating facilities.

   These perks can add up to savings, putting more money back in your pocket.

Sanford Health Plan encourages you to speak with a licensed agent for customized assistance as you start shopping for individual and/or family health insurance. Call **(888) 861-5171 (TTY: 711)** to speak with an agent from 8 a.m. to 5 p.m. CST, Monday through Friday, or visit **sanfordhealthplan.com/get-a-quote.**

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