

Health Insurance for Entrepreneurs

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



**Reflecting
changes from
2010 health
reform laws**



Health Insurance for Self-employed and Small Business Owners

Introduction

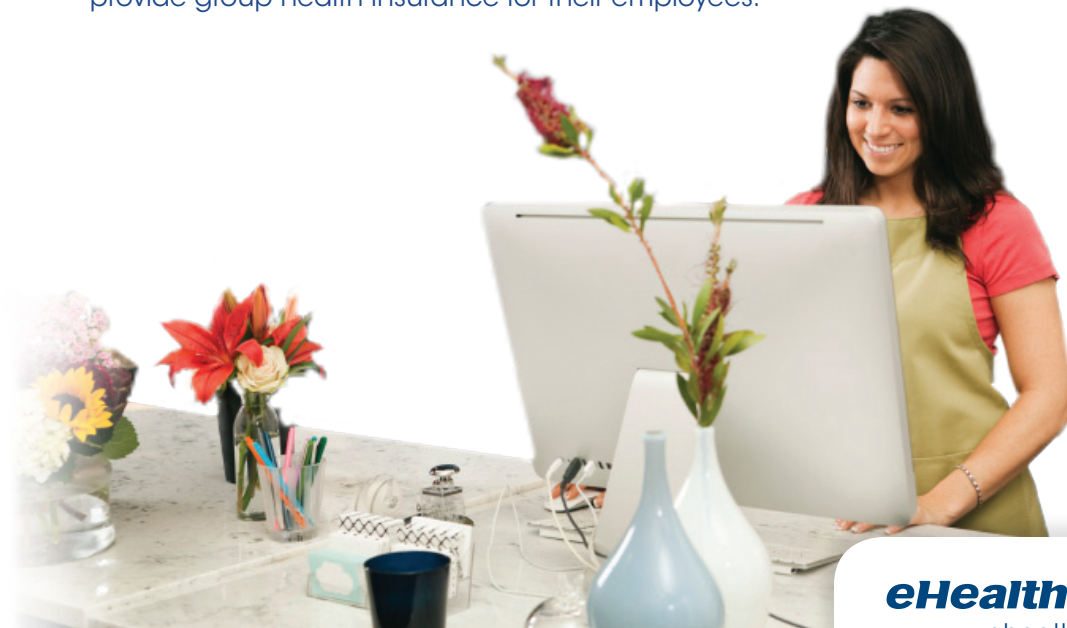
Building a successful business is hard work. Finding the affordable, quality health insurance you need doesn't have to be. Whether you're self-employed and working out of your garage or the owner of a small business with multiple employees, you face special challenges when it comes to finding and getting health coverage. 2010 health reform legislation provides you with special opportunities too. 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.

Self-employed Persons

Going into business for yourself can be a big gamble. Don't raise the stakes any higher by doing it uninsured. You may be on a tight budget. You may think health insurance is a luxury you can't afford. In fact, the primary purpose of health insurance is to protect your financial future against crippling medical costs that may arise from unexpected illness or hospitalization. The truth is, if you're a freelancer, consultant or sole proprietor, you can't afford to go without coverage.

Small Business Owners

Whether you've got two employees or 25, you know that employer-sponsored health insurance is one of the benefits workers value most. Offering a group health insurance plan can help you hire and retain the best workers as well as provide valuable protection for yourself and your family. And as a result of health reform, there are special tax incentives available from 2010-2013 for small businesses that provide group health insurance for their employees.





Health Insurance for Self-employed and Small Business Owners

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.



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 health reform law 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 this 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.



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 twice as high.
- **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.

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 broad network of health care providers.
- **It provides you critical care** – While uninsured patients will often get emergency-room care and be billed afterwards, they may not get important treatment for a life-threatening chronic condition without an up-front payment.
- **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 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.



Key Concepts and Terms

Individual and Family vs. Small Group Coverage

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. Depending on the number of employees you have and the regulations in your state, you may qualify for either one. In some states, however, self-employed persons without any additional employees may only be eligible to apply for individual and family coverage.

Comparing Individual & Family and Small Business Plans

	Provides coverage for self and family	Provides coverage for employees	May have to qualify as a business in your state in order to purchase	Can be declined coverage due to medical history	Tax deductions or incentives available in some cases
Individual and family health insurance					
Small business/group health insurance					

"Individual and Family Plans"

Like the name implies, these are health insurance plans purchased by individuals to cover themselves or their families. Anyone can apply for an individual and family plan. Self-employed persons often purchase these kinds of plans, though some may also qualify for small business/group plans. Small business owners who can't afford group coverage may purchase individual and family plans for themselves or their families. Until federal health insurance reforms take full effect in 2014, it will still be possible (in some states) to be declined for individual or family coverage based on a pre-existing medical condition. Self-employed persons who purchase their own health insurance may be able to deduct the cost of their monthly premiums in some cases.

"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 are special tax incentives available to businesses providing group coverage to employees, and no one in a group can be turned down due to a pre-existing medical condition.



Key Concepts and Terms

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:

1 "PPO"

PPO or "Preferred Provider Organization" plans are the most popular in the individual and family market. Like the name implies, persons covered under a PPO plan 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 PPO: you can sort for plans accepted by your doctor after getting quotes at eHealthInsurance.com
- You want some freedom to direct your own health care but don't mind working within a list of preferred providers

2 "HMO"

HMO stands for "Health Maintenance Organization." HMO plans offer a wide range of health care services through a network of providers that contract exclusively 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, though there may be exceptions in case of 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 value preventive care services: coverage for checkups, immunizations and similar services are often emphasized by HMOs



Key Concepts and Terms

Top Four Health Plan Types (Cont.)

3

"HSA-eligible Plans"

These are usually PPO plans with higher deductibles, designed specially 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 gain 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.ehealthinsurance.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
- 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

4

"Indemnity"

Indemnity plans allow members to direct their own health care and visit most any doctor or hospital they like. The insurance company then pays a set portion of the total charges. Members may be required to pay for some services up front and then apply to the insurance company for reimbursement. Because of the freedom they allow members, Indemnity plans are sometimes more expensive than other types of plans.

An Indemnity plan may be right for you if:

- You want the greatest level of freedom possible in choosing which doctors or hospitals to visit
- You don't mind coordinating the billing and reimbursement of your claims yourself



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.ehealthinsurance.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 if you want to save money now, and a higher premium/lower deductible if you want to be more financially prepared for unexpected medical expenses later.

"Copayment" – Your copayment, or "copay," is the specific dollar amount you may be required to pay up front for a specific type of service. For example, your health insurance plan may require a \$15 copayment for an office visit or brand-name prescription drug, after which the insurance company pays the remainder of the charges.

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





Know the Lingo

Five Health Insurance Terms You Must Know (Cont.)

"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.

"Coinsurance" – Coinsurance is the amount that you are 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.

"Maximum Out-of-pocket Costs" – 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.





What Health Reform Means for You

Understanding Health Reform

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 employees and those with fewer than 50 employees.

In 2014, 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. That same year, individuals who do not get health insurance through an employer will be required to purchase coverage on their own too.

Self-employed persons and businesses employing fewer than 50 workers may benefit from health reform in the following ways:



Strengthened protections for individual and family coverage

Beginning in 2010, consumers will no longer face strict dollar limits on how much lifetime coverage their health insurance company will provide, and insurance companies will no longer be able to cancel someone's coverage after they get sick.



No more job lock

Persons who may have wanted to start their own business but were afraid to give up employer-sponsored group health insurance coverage will gain some entrepreneurial freedom. Once health reform provisions are fully implemented in 2014, it will no longer be possible for insurance companies to decline coverage for individuals with pre-existing medical conditions.



Special tax credits for 2010-2013

During this period, small businesses with fewer than 25 employees and annual average wages of \$50,000 or less may qualify for special tax credits if they choose to provide group health insurance coverage and pay at least 50% of employee premiums. Businesses who qualify for the maximum credit (those with fewer than 10 employees and average wages of \$25,000 or less) will receive a tax credit equivalent to 35% of the amount the employer pays toward employee health insurance premiums. Talk to your accountant to learn more.



What Health Reform Means for You

Understanding Health Reform (Cont.)



Small business insurance exchanges

Starting in 2014, small businesses with up to 100 employees will be able to purchase group coverage through state-based Small Business Health Option Program (SHOP) exchanges. The hope is that these exchanges will allow small employers to pool their resources and risk factors into larger groups and so qualify for less expensive insurance rates. Small businesses of fewer than 25 full-time employees who qualify for the credits discussed above and who also purchase their coverage through the SHOP exchanges after 2014 will continue to receive special tax credits for an additional two years.

Health Reform Mandates for Self-employed Persons and Small Business Owners:

	Self-employed Persons with No Employees	Small Business Owners with <25 Employees	Small Business Owners with >25 Employees	Small Business Owners with >50 Employees
Must have some form of personal health insurance coverage starting in 2014				
Must provide group coverage to employees in 2014				
May receive tax credit if providing group coverage prior to 2014				

"Will I be required to purchase health insurance for my employees?"

Not necessarily. Only businesses with the equivalent of 50 or more full-time employees will be obliged to purchase group health insurance, beginning in 2014. Persons who do not get their health insurance through employers after 2014 will be required to purchase it on their own.

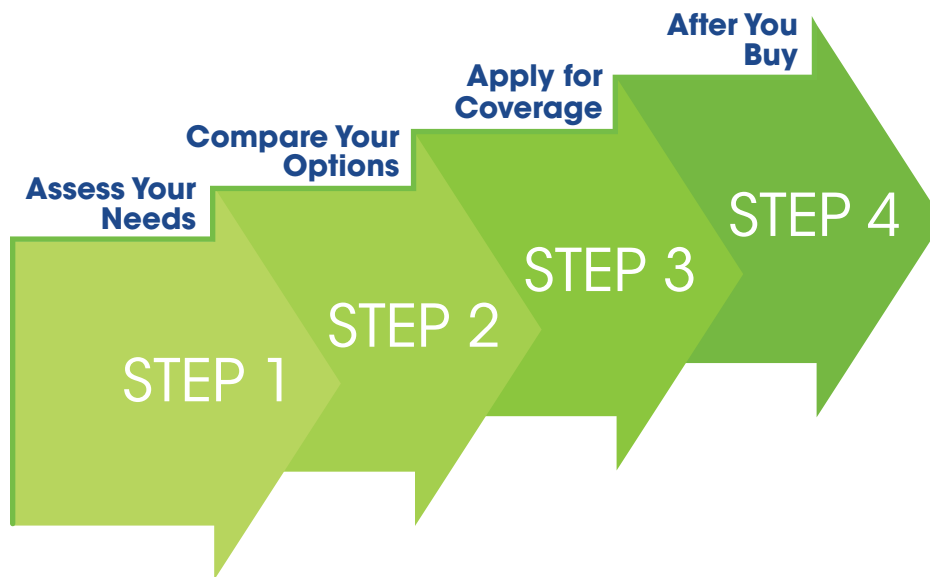


Self-employed

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. Others are so-called “accidental entrepreneurs” who were laid off in the recession but took the opportunity to pursue business ideas of their own.

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 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 One - 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.

Seven questions to help you assess your needs:

☐ 1. "Who will be covered under this plan?"

Why it matters: It may sound like a dumb question. You probably want to cover yourself and your dependents. But ask yourself: does anyone in your family have other coverage options? If you really can't afford to cover everyone, who needs coverage most, and why? You may actually be able to save money by covering different members of your family separately under two or more plans.

☐ 2. "Do you maintain a savings 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 low deductible, or none at all. If you do keep a savings and can afford a higher deductible if necessary, you may be able to find a plan with lower monthly premiums.

☐ 3. "How often did you visit the doctor last year?"

Why it matters: If you visit the doctor 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, maybe you don't need robust coverage for preventive care.

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

Why it matters: If you spend a lot on health care, it's important to know what you spend it on 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. If you don't spend much on health care, then you could save money with a plan that provides less generous coverage for office visits or prescription drugs.



Step One - Assessing Your Needs

Understanding Your Needs (Cont.)

☐ 5. "Do you have any pre-existing medical conditions?"

Why it matters: Some pre-existing medical conditions (like heart disease, cancer, or diabetes) can make it difficult to get approved for Individual and family coverage. If you're concerned, a licensed eHealthInsurance agent can help direct you to insurance companies more likely to approve your application. Call **1-800-977-8860** to talk to an agent.

☐ 6. "Are you eligible for group health insurance coverage?"

Why it matters: In most states, self-employed persons buying health insurance on their own need to purchase individual and family plans. However, some states allow persons with business licenses to purchase small business/group plans, even without employees. If you have a pre-existing medical condition, a small business/group plan may be a better option, since with group, you can't be turned down for coverage. 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.

☐ 7. "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 maternity benefits too. If you don't need prescription drugs or maternity benefits, you could save money.

"What if I have a pre-existing medical condition?"

In most states you can be still declined for individual and family coverage due to a pre-existing medical condition until 2014. However, you may still have options. Talk to a licensed agent at eHealthInsurance for help. If we can't find an insurer likely to accept you, we can help direct you to government-sponsored solutions in your state.



Step Two – 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 a licensed agent like eHealthInsurance you can save time and get a selection of quotes from top insurance companies in your area.

Get free, instant health insurance quotes and advice from eHealthInsurance

eHealthInsurance makes it easy to find the right health insurance plan for your needs and budget. Unlike many other online services, eHealthInsurance won't require you to provide any sensitive personal information before getting your quotes. Just go to **eHealthInsurance.com**, enter your ZIP code and your age, and get:

- **Instant personalized quotes** from a broad selection of top carriers
- **Side by side comparisons** of plan rates and benefits
- **Special online tools** that generate personal recommendations based on your needs or identify plans accepted by your favorite doctor
- **Customer reviews and industry ratings** to help guide your decision
- **Personal, unbiased help from licensed agents** by phone, email, or online chat





Step Two – Comparing Your Options

Getting Quotes and Researching Options (Cont.)

Choosing a Plan

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? Buy only what is important to you to keep your costs low. Avoid plans offering expensive benefits (like maternity or prescription drugs) if you don't need them.
- 2. Costs:** Which plans fall within your budget when it comes to premium, deductible, co-payments and coinsurance? Consider a high-deductible plan if your primary requirement is a low monthly premium.
- 3. Physician network:** Do you have a favorite doctor you want to keep? Which plans does he or she accept? At **eHealthInsurance.com**, you can use our "Plans with Your Doctor" tool to see only those plans that are accepted by your doctor.
- 4. Brand:** Are there brand-name carriers that you prefer? Are there any you want to avoid?
- 5. Consumer and industry reviews:** eHealthInsurance lists customer reviews for many of the plans we sell, and we present the AM Best ratings for carriers. These ratings reflect AM Best's analysis of a company's credit rating and ability to pay claims.

*If you're reviewing your health insurance options on **eHealthInsurance.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. eHealthInsurance's own licensed agents and representatives can be reached by phone, email or online chat.*





Step Three – Applying for Coverage

The Application Process

Completing Your Application

Once you've selected the health insurance plan that you'd like, complete the application. If you're working through an online health insurance agent like eHealthInsurance, you may be able to complete your application online. Be sure to answer all questions honestly. You may find that you'll need to contact your doctor's office for information like the date of your last checkup. It's better to provide correct information up front than for the insurance company to discover that you omitted specific elements of your medical history.

Submitting Your Application

If you're applying through an online health insurance agent like eHealthInsurance, you may be able to submit your application electronically, to save time and hassle. You may be required to provide a check or credit card for your first month of coverage. If you are denied coverage, this money will be refunded to you by the insurance company. Your application materials will be forwarded by your agent to the health insurance company where it will be reviewed. If you submit your application through eHealthInsurance, we will inform you of the insurance company's decision as soon as possible. You may receive any one of the following responses:

- **"You're approved!"** Once approved, your health insurance coverage will begin on the "effective date" confirmed by the insurance company.
- **"You're approved, with conditions."** The insurance company may offer you coverage but limit benefits for specific conditions based on your medical history.
- **"More information is required."** In some cases, the health insurance company will ask for more information regarding your application, and may request medical records from your doctor before coming to a final decision.
- **"Your application is denied."** If the insurance company declines your application, please talk with one of our licensed agents by phone. There may be reason to appeal the decision or try again with a different insurance company. If not, we can help put you in touch with government-sponsored options available in your state.

"Isn't it cheaper if I buy directly from the insurance company?"

No. Due to government regulations, you will pay the same monthly premium for the same plan whether you buy it from a licensed agent or direct from the insurer. So, for no additional cost, shopping through a site like **eHealthInsurance.com** can give you more objective, unbiased help to find the right plan. With eHealthInsurance, you also get access to 24/7 customer support, customer reviews for many of the plans we sell, a plan recommendation tool and another tool that identifies all the plans accepted by your favorite doctor.



Step Four - 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. Because of his or her relationship with the health insurance company, your agent can help you understand how your benefits work and serve as your advocate to clear up billing disputes.

Adding and Removing Dependents

Marriage, the birth of a child, or an older child's college graduation 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 your list of covered benefits. 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

eHealthInsurance recommends health insurance policyholders take a fresh look at their medical coverage once a year 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.



Step Four - After You Buy

After Purchasing a Plan (Cont.)



Does my current plan cover the services I need?

If you're paying for benefits you don't use (such as prescription drugs, maternity or chiropractic care), you may be able to find a plan with a lower monthly premium that excludes those benefits. On the other hand, if you 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, even if your monthly premium increases.



Have I experienced any big life changes?

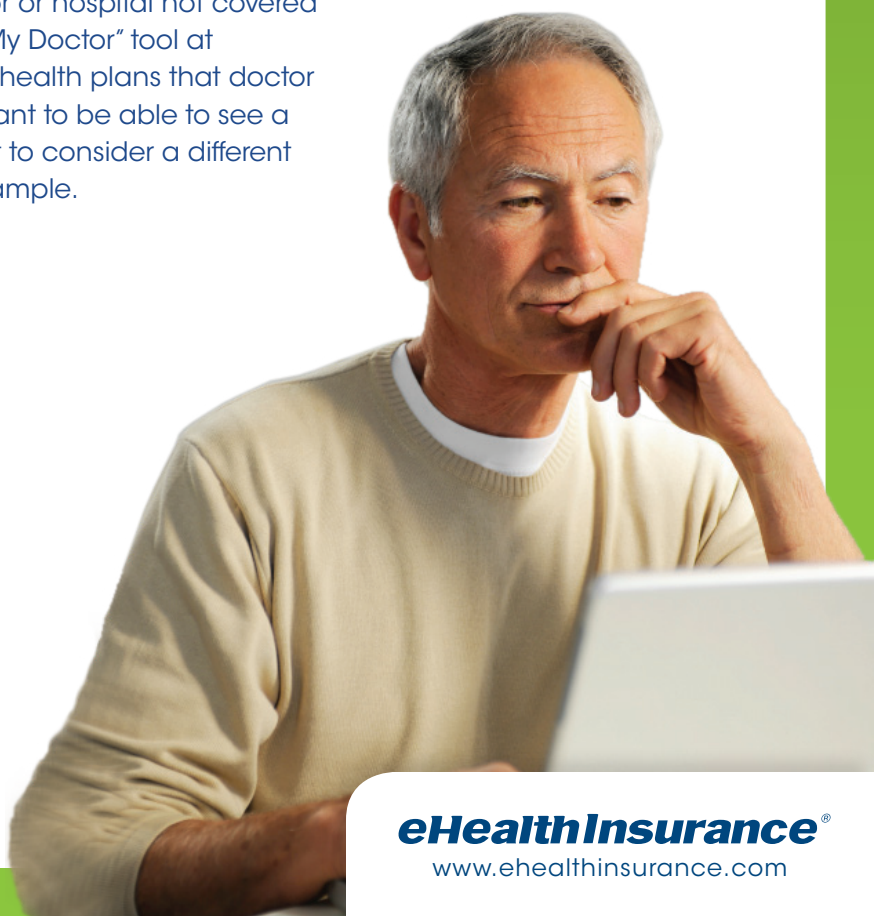
If you were recently married or divorced, had a child, or gained or lost income – or if you anticipate these things happening in the year to come-, it may be time to reconsider your health insurance options. And if you recently turned 30, 40, 45, 55 or 60 years old, you may find that your rates were increased because of your age. 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 to 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, use the "Plans with My Doctor" tool at **ehealthinsurance.com** to find out which health plans that doctor 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 plan, for example.

NOTE: Keep in mind that until the final provisions of health reform are implemented in 2014, every time you switch plans or apply for a new individual or family health insurance plan you will be subject to medical underwriting. If you have an individual or family plan and developed medical conditions recently, you may need to stay on that plan to retain your coverage.



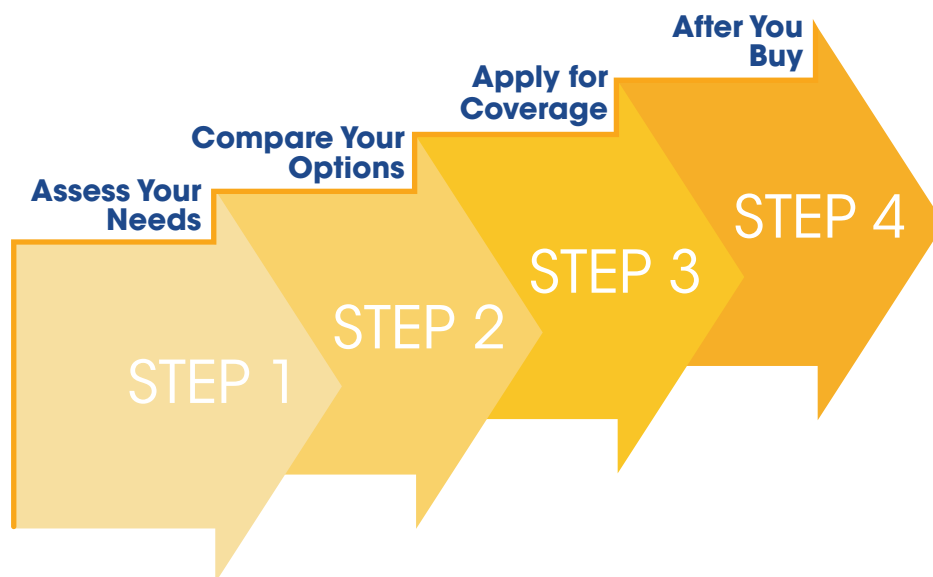


Small Business

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 One - Assessing your Needs

Understanding 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? Which benefits are 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:

☐ 1. "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 already have coverage through spouses or other family members. If you're unable to assist employees with their health insurance needs, then read the portion of this guide dedicated to self-employed persons, since it focuses more on individual and family coverage.

☐ 2. "How much cost-sharing can you afford?"

Why it matters: Group health insurance is employer-sponsored coverage, but monthly premiums are paid for by both the employer and employees. In most states, employers are 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.

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

Why it matters: 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. It's important to find a balance of monthly premium and deductible that works for as many people in your group as possible.



Step One - Assessing your Needs

Understanding Your Needs (Cont.)

☐ **4. "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 regular checkups with a low copayment? How important are benefits covering prescription drugs or maternity care? Understanding the benefits most valued by your employees can help you find a plan more likely to meet everyone's needs.





Step Two – Comparing Your Options

Getting Quotes and Researching 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 eHealthInsurance you can save time and get a selection of quotes from top insurance companies in your area.

Get free quotes and personal advice from eHealthInsurance

eHealthInsurance 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. eHealthInsurance makes it easy to find the right health insurance plan for your needs and budget.

Visit us online at **eHealthInsurance.com**, then contact one of our small business health insurance representatives by phone at **1-877-456-6670**.

When you shop with eHealthInsurance you'll get:

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

Choose a Plan

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:

- 1. Health benefits:** Buy only what is important to you and your employees. Avoid plans offering expensive benefits (like maternity or prescription drugs) if you don't need them.
- 2. Costs:** Which plans fall within your budget when it comes to cost sharing between employer and employees, monthly premiums, deductibles, copayments and coinsurance? Consider a high-deductible plan if your primary requirement is a low monthly premium.
- 3. Brand:** Are there brand-name carriers that you prefer? Are there any you want to avoid?
- 4. Industry ratings:** eHealthInsurance identifies the AM Best ratings for carriers. These ratings reflect AM Best's analysis of a company's credit rating and ability to pay claims.
- 5. Coverage add-ons:** Do you want to offer your employees dental or vision coverage? Some group health insurance plans will allow you to add them onto your medical coverage rather than buying them separately.

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



Step Three – 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

One of the benefits of small business/group health insurance is that, 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 by the insurance company.

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 to guarantee that everyone is enrolled. When you work with eHealthInsurance as your agent, a representative assigned to you can help walk you through the process.





Step Four - 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.

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 serve as your advocate to clear up billing disputes.

Adding and Removing Covered Persons

Employees will 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 make sure that all these changes are made in a timely and effective manner.





Step Four - After You Buy

After Purchasing a Plan (Cont.)

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 make changes to your covered benefits, or the amount they pay out per year for specific conditions. Be sure to read through the updates provided by your insurance company and contact their customer service department or your agent for more information.

Open Enrollment

With group health insurance products, employers are typically committed to a specific plan for one year. When that anniversary approaches, you’ll enter your open enrollment period. eHealthInsurance 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:

- **Are we 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 agent like eHealthInsurance will often contact you when open enrollment comes 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’re paying for benefits you don’t use (such as prescription drugs, maternity or chiropractic care), you may be able to find a plan with a lower monthly premium that excludes those benefits. 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, please contact:

- A licensed eHealthInsurance agent at **800-977-8860**
- Or go online to **eHealthInsurance.com** to read FAQs, get free quotes, compare plans, and apply online
- You may also want to check out our guides and resources for more tips on individual and family or small business insurance products

If you are unable to qualify for or afford individual health insurance, you may be eligible for government-sponsored coverage. For information about public programs please contact:

- The Foundation for Health Coverage Education (FHCE) at **800-234-1317**
- Or go to their web site is **www.coverageforall.org**
- Or check your local state insurance commission's website

To learn more about health reform and individual and family health insurance, visit:

- **www.healthcare.gov**





Glossary of Insurance Terms

Below is a selection of common health insurance terms. At **eHealthInsurance.com** you'll find a larger glossary of terms and answers to frequently asked questions, in addition to other resources. Please note that the definitions below 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.

Agent: A licensed agent is a person approved by the state to sell health insurance. An agent works to match applicants with the health insurance company or plan best matched to their needs. Agents are paid a commission by the insurance company, but represents the applicant rather than the insurance company itself. It does not cost anything extra to work through an agent. An agent can continue to serve you after you buy, to help resolve 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 healthcare 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 maximum 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 in late summer or fall.



Glossary of Insurance Terms

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 by a health care provider.

Coinsurance: The amount that you are 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 \$15 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. Not all health insurance plans require a deductible.

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.

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



Glossary of Insurance Terms

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

Employer Contribution: The portion of an employee's health insurance premium paid for 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.

Exclusions: Specific conditions, services or treatments for which a health insurance plan will not provide 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.

Guaranteed Issue: A term used to describe insurance coverage that must be issued regardless of an applicant's health status. In most states, group health insurance plans are often described as "guaranteed issue" plans, because a health insurance company generally cannot refuse coverage to a qualifying business or organization based on the health status of their employees or members. After the full implementation of health reform law in 2014, health insurance companies in every state will provide 'guaranteed issue' to all applicants.

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. HIPAA also helps consumers to obtain or retain health insurance coverage in certain circumstances.



Glossary of Insurance Terms

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. 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. Until health reform law is fully implemented in 2014, insurers in most states may decline coverage for individual or family health insurance based on the medical conditions or health histories of applicants or their dependents.

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.

Managed Care: A general term used to describe a variety of health care and health insurance models that attempt to guide a member's use of benefits, typically by requiring that a member coordinate his or her health care through a primary care physician, or by encouraging the use of a specific network of health care providers. The management of health care is intended to keep costs - and monthly premiums - as low as possible. Most HMO, PPO, and POS plans are considered managed care plans.

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.



Glossary of Insurance Terms

Network Provider: A health care provider 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.

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, etc.

Pre-existing Medical Condition: A health problem or diagnosis that existed before your application for health insurance or before the effective date of your new health plan. Many individual and family health insurance contracts have a pre-existing condition clause that describes conditions under which the health insurance company will cover medical expenses related to a pre-existing condition.

After health reform is fully implemented in 2014, it will be illegal for most health insurance companies to deny coverage based on an applicant's pre-existing medical conditions.

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

Preventive Care: Medical care rendered not for a specific complaint but focused on prevention and early-detection of disease.

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.



Glossary of Insurance Terms

Rate Guarantee Period: The length of time that the insurance company guarantees a new member will not face any increase in his or her monthly health insurance premiums. Not all health insurance plans come with a rate guarantee period and moving into a new age bracket may make a rate guarantee invalid in some cases.

Referral: The process by which a patient is authorized by his or her primary care physician to 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: Short-term health insurance plans are similar to individual and family health insurance plans. However, coverage typically extends for no more than 6 months and benefits are often less comprehensive than those provided by a long-term health insurance plan. Prescription drugs, preventive care, and treatment for pre-existing conditions are usually not covered.

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.



Glossary of Insurance Terms

Underwriting: The process by which an insurance company determines whether it will accept an application for individual and family coverage, based upon risks and projections, and through which a final determination on monthly premium is made.

Waiting Period: A period of time beginning with your effective date during which a health insurance plan may not provide benefits for certain pre-existing conditions. This period may be reduced or waived based on any prior health care coverage you had before applying for your new health insurance plan.

