Choosing a plan

There are three important things to keep in mind when you are choosing a health insurance plan:

1. Does the plan include the doctor, clinic or hospital that you use?
2. Does the plan cover your medical needs?
3. Does the plan fit your budget?

Let's take these questions one by one, and look at how you will be able to find the answers when you are applying for health insurance through the new exchanges, or marketplaces, that will begin enrolling people on October 1, 2013.

Does the plan include the doctor, clinic or hospital that you use?

When you are filling out the on-line application for health insurance, you will have an opportunity to search the available health plans to see if they include your personal health care providers, such as the doctor, midwife or nurse practitioner you are currently seeing. If you like the doctor, clinic or hospital you use regularly, you should make sure to choose a plan that includes these providers.

This step is especially important for women in our reproductive health years, because it can be hard to find an obstetrician/gynecologist or women's health clinic that we really like, and we don't want to risk losing that provider. It's also important for LGBT people, who often have difficulty finding a health provider who understands our medical needs and treats us with respect.

If you are visiting the office of a navigator or an in-person assistor to get help in filling out your health insurance application, make sure to take the name and address of your favorite health providers with you. Ask the person helping you to search the available health plans for the ones that include your health providers. Then choose one of those plans. If you do not choose a plan that includes your favorite health providers, you could face having to pay extra charges when you seek medical care from that provider.

Does the plan cover your medical needs?

Fortunately, the health insurance plans that will be sold in the new exchanges, or marketplaces, will be required to cover 10 important types of health care that are known as "Essential Health Benefits." These are: ambulatory patient services (outpatient care); emergency services; hospitalization; ma-

ternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Because of this requirement, health plans will cover many of the types of care most people need. One exception, though, is dental care for adults. Children's dental care is covered, but adult dental care is not. You will have to pay extra to get that dental care. Another exception is abortion services. Some states will allow health plans to cover abortion, but you may find that not all of the plans do so. Other states have prohibited or restricted abortion coverage. If you want to be sure your plan will pay for abortion care if you need it, make sure to ask about that when you apply. Transgender individuals should also ask about whether health plans will cover hormones, surgery and other care they need.

If you have special medical needs, such as ongoing treatment for a chronic condition or cancer, you will be relieved to know that health plans will not be allowed to deny you insurance because of your having a pre-existing condition. However, each plan may not cover all the medical treatments you need. So, it is important for you to have information at hand about your health condition when you are choosing a plan, and make sure to ask whether all your treatments will be covered. You will also want to think carefully about which "level" of a health plan you choose (bronze, silver, gold or platinum) if you have a medical condition that requires you to visit the doctor regularly and/or have lots of tests. See more about this topic in the next section.

Does the plan fit your budget?

The health plans sold in insurance exchanges, or marketplaces, will generally cost less than other comprehensive health plans. You may be able to pay even less if you qualify for financial aid that will be available. Make sure to have your pay stub and any other important financial information handy when you sit down to apply for a new health plan. You will be asked a series of questions that will help estimate what your income will be in 2014, when the coverage goes into effect, and this amount will determine if you can get financial aid. If you qualify, you can apply this aid directly to your monthly premium, bringing down your cost.

But you will also have to decide what "level" of a health plan you want to buy – bronze, silver, gold or platinum? What do these levels mean? If you choose a bronze plan, you will have a lower monthly premium, but have to pay higher out-of-pocket costs (co-pays or deductibles) when you go to the doctor, have a test or use other medical services. By contrast, the premium for a gold or platinum plan will be higher, but the out-of-pocket costs will be lower. So, if you go to the doctor often or have a lot of medical tests and treatments, you may be better off choosing a gold or platinum plan and paying a higher monthly premium, because you will save on out-of-pocket costs, costing you less in the end. In general, experts are advising against choosing the bronze level plan, despite its lower monthly premium, because the out-of-pocket costs could really add up if you have an unexpected illness or accident. Lower-income people (under $27,000 a year for an individual or $55,000 for a family of four) can also get financial aid to help with co-pays and deductibles, but only if they buy a silver-level plan.