A Health Insurance Guide for Young Adults

How can I get on my parent’s health insurance?
- If your parent has health insurance through their job, you can often stay on their plan until age 26, and in some cases age 29, but this varies by insurance.
- Unfortunately, the latest that you may be allowed to stay on your family’s Medicaid plan is age 19.
- If you would like to seek confidential sexual and reproductive care, you may be interested in applying for the Family Planning Benefits Program (FPBP) to ensure that these services are billed separately from your parent’s insurance.

What should I consider when choosing a health plan?
- Costs:
  - Monthly premiums: how much you pay every month for the insurance plan
  - Deductibles: how much you pay out of pocket for care before insurance pays
  - Co-insurance and co-pays: your out-of-pocket costs for office visits (primary care and specialty), prescriptions, etc.

- Services covered:
  - Consider if mental health, dental and prescriptions are covered

- Plan exclusions:
  - What services your plan doesn’t cover

- How many doctor visits you think you may need during the year (consider if you have any chronic illness that may require regular medical visits)
- How often you need medication
- Coverage for your doctors and specialists: in-network vs. out-of-network (see glossary)
- Availability of a flexible spending account or a health savings account from your employer to help lower any future costs

How does disability impact health insurance?
- If you have a disability and are unable to work because of it, you can stay on your parent’s private health insurance even after you turn 26 years old. You may need to submit additional documents to complete this process. Please check with your insurance for more information.
- If you have a disability and are covered under your parent’s Medicaid insurance plan, you must switch to your own Medicaid insurance plan at age 19. In order for your parent to communicate with your insurance plan, you must sign a release form.

The Affordable Care Act (ACA) made a huge impact on our health care system and the way insurance works. It was designed to make health insurance coverage more fair, affordable and easy to understand. The ACA also expanded Medicaid eligibility to cover more people with lower incomes and created a health insurance marketplace.

What is commercial or private insurance?
- Commercial insurance is managed by private insurance companies and is usually offered through your job. This means your employer shares part of the cost of buying insurance. If your employer does not offer insurance plans, the health insurance marketplace is available for individuals to purchase commercial insurance.

What is public insurance?
- Public health insurance includes government supported programs like Medicaid and Medicare. Medicaid helps eligible people with low to medium incomes pay for health insurance. If you are pregnant and under age 18, you can apply for Medicaid regardless of immigration status and income. Please visit www.health.ny.gov/health_care/medicaid/ for more information.

Managed care plans are health insurance plans that have contracts with health care providers and/or medical facilities to provide care at a lower cost. There are different types of managed care plans such as: HMO, PPO, POS and EPO (see glossary).

What are student health programs?
- Students are often required to have health insurance, and colleges may offer health insurance to students called student health programs (SHP). Students may need to enroll in a SHP or prove they have other insurance coverage that is at least as good (“comparable coverage”). Please keep in mind that coverage from SHPs may not be enough if you have chronic medical conditions or take medications regularly.
You will be responsible for covering some, if not all, of your health care costs. Your parent/guardian's health insurance, Health insurance marketplace, and Your college/university (Student Health Program) are some options that may cover your medical expenses. Your job/employer may also cover some of your health costs, and you may be required to make a payment if you do not have minimum essential coverage.

What if I do not have health insurance?

You may be required to make a payment if you do not have minimum essential coverage or a coverage exemption when you file your tax return. To find out if you qualify for a payment or exemption, please visit: www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-calculating-the-payment.

Where can I get health insurance?

Your employer, your college/university (Student Health Program), Health insurance marketplace, or through Medicaid are some options where you can get health insurance. Your job/employer may also cover some of your health costs, and you may be required to make a payment if you do not have minimum essential coverage or a coverage exemption when you file your tax return.

What is health insurance?

Health insurance is a way to pay for your health care. It protects you from having to pay the full costs of medical services if you are injured or sick. Health care plans are available through government programs, insurance companies, or employers.

Why is health insurance important?

Each health insurance plan is different and covers different medical costs. Health insurance gives you access to free care, protects you from having to pay the full costs of medical services if you are injured or sick, and allows you to get medical care when you need it. It gives you access to free care to prevent certain illnesses, like diabetes, and focus on prevention and wellness. Health insurance is a way to pay for your health care. It protects you from having to pay the full costs of medical services if you are injured or sick.

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Resources

Family Planning Benefits Program (FPBP): A public health insurance program for New Yorkers who need family planning services, but may not be able to afford them. Medicaid: The official New York Medicaid website. Medicaid.gov: A website for more information on tax penalties and exemptions. HealthCare.gov: A website for additional information, including a glossary health care of terms. Why is health insurance important?

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Glossary

Chronic Illness: A medical condition that is expected to last more than 3 months and usually requires ongoing care.

Co-insurance: Amount that you are required to pay for health care services, after a deductible has been paid. Co-insurance is often specified by a percentage of the total cost. For example, you may pay 20 percent toward the cost of a service and your insurance company may pay 80 percent.

Co-pay: A fixed amount you pay for covered health care services usually at the time of your visit. Generally, plans with lower monthly premiums have higher co-payments and plans with higher monthly premiums usually have lower co-payments.

Deductible: Amount that you must pay for health care expenses before insurance covers the costs. Often, insurance plans are based on yearly deductible amounts.

Exclusions: Conditions, treatments and other services that a health plan will not cover. These may be due to things like your age, gender, or health status. Exclusions may be covered by an indemnity plan.

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Flexible Spending Account (FSA): An account you set up through your employer to pay for most medical expenses that are not covered by your health insurance plan.

Health Maintenance Organization (HMO): A type of health insurance plan where services are covered only if you use doctors, hospitals, and providers in the plan’s network (except in an emergency). HMOs usually limit coverage to care from doctors who work for or have a contract with the HMO. You generally won’t cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide coordinated care and focus on prevention and wellness.

Medicaid: A medical condition that is expected to last more than 3 months and usually requires ongoing care.

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