



Identifying the Right Policy Among a Sea of Plan Options

Your decision
Impacts the Next
12 Months of
Health Coverage
& Costs

Choosing insurance coverage is a big decision that can impact your family's health and financial situation for the year.

Before selecting a new health plan, be sure to take a look at your family's current healthcare needs.

Knowing things like your family history, potential risk factors, and preferred doctors are all important factors that will help you choose the right plan.

For example, if your child has allergies, you'll want to look for a plan that allows for specialist doctor visits that won't break your bank.

After outlining your needs, you'll want to compare plans that accommodate them at the most reasonable cost to you.

All Plans are Not Created Equal

Some plans might have higher deductibles but come with better prescription plans. For a family member that requires an expensive medication, choosing this kind of plan might be the better option. If you or a family member find yourselves in and out of the doctor's office, a plan that has a higher premium might save you in the long run. If you or someone in your family has high-cost medical needs, try looking for a policy that has lower total cost sharing amounts. These costs are in addition to the deductible, co-payments, and co-insurance add up to your out-of-pocket maximum. This is in addition to the monthly premium you must pay to keep the policy active.

10 Questions to Ask Yourself When Choosing a Plan

- 1 What is the deductible that I must meet first before my insurance starts to pay? Do I have a separate medication deductible and medical deductible?
- 2 What are the out-of-pocket costs for providers, specifically co-payments and co-insurance amounts? What is an estimate for the total of these amounts?
- 3 Is my preferred doctor(s) in the plan network? (If you do choose to use a doctor that is out-of-network, you'll want to understand how much will be reimbursed by the plan).
- 4 How much is my monthly premium? Do I qualify for any premium tax credits?
- 5 Do I need a referral to see a specialist?
- 6 Does my plan offer access to the specialists I need or want to see?
- 7 Are the prescriptions I'm current taking covered by the plan? (Are they listed on the plan formulary?)
- 8 Does my plan include coverage if I have to visit an out-of-network provider, even for urgent or emergency care?
- 9 Does my plan qualify me for additional saving options like Health Savings Accounts, Flexible Spending Accounts or Cafeteria plans?
- 10 What do I need for dental or vision coverage? (Health plans don't often cover dental or vision services and you may want to consider purchasing separate plans.)

Stay Organized and Seek Help if You Need It

Jot the answers down in a notebook so you can easily compare plans to determine which option is best for you and your family. If you're still not sure which plan to choose, every insurer has a contact number you can reach out to if you have any questions. They'll help you evaluate your needs to steer you toward a plan that best fits your needs.

It may seem like a lot of work, but your time and energy researching and comparing plans will be worth it in the long run, and help you reduce your costs throughout the year.

Tools to Help You Compare

Finder.Healthcare.gov allows you to compare plans side by side, and contains tools to help you analyze how medical expenses impact your family's budget.

CancerInsuranceChecklist.org provides guidance on the important items to consider in your plan options when diagnosed with a serious condition, even if not cancer-related.

nerdwallet.healthsherpa.com is an online tool that will present you with plan recommendations in your area.

A downloadable spreadsheet tool can be found at www.businessinsider.com/spreadsheet-for-picking-perfect-healthcare-plan-2016-11 that helps capture and calculate your expenses.

Exclusive Provider Organization (EPO) Plan – This plan is like an HMO plan in that members are required to use only network doctors. Frequently these providers are part of the same health system or hospital and may not offer a lot of variety outside of what that system provides. However, unlike an HMO plan, it is not necessary to select a PCP, or contact a PCP for specialist referrals. There is generally no coverage for care received outside of the provider network.

High Deductible Health Plan (HDHP) – A high-deductible health plan can be any one of the other types but follows specific rules to be considered “HSA-eligible” These plans generally offer lower premiums, but you may pay higher out-of-pocket costs, especially before meeting your deductible. If you choose an HSA, you can open an account called a Health Savings Account (HSA) to save money for medical expenses. When you withdraw funds to use for qualified medical expenses, you do not have to pay taxes on the money.

Making Sense of the Different Types of Plan Structures

What Kind of Plan is Best?

Below are some types of plans you may see while evaluating your options for health insurance. Knowing how each is structured will help you choose the right one for you or your family. Each of these plans requires a monthly payment, known as a premium, to maintain coverage. Some will have higher premiums, and some will have lower premiums, but the premium amount should not be the only factor you consider. Ease of access, the doctors within the provider network, out-of-pocket costs, and benefits that are offered impact your cost and convenience using the plan. There is no obvious ‘favorite or best’ plan across the board, instead each plan type may be geared for a different scenario and medical need. Only you will know what will work best for you.

Consider these major elements of each structure.

Health Maintenance Organization (HMO) Plan – In this plan, your Primary Care Provider (PCP) is who you will need to reach out to first. The insurer requires the PCP to direct your care and be a centralized source for information. If you need care outside of what your PCP can offer, your PCP will be required to provide a referral to a specialist in order for it to be covered. There is a wide variety in provider selection for HMOs. Some offer very broad options and some very narrow. HMOs offer no out-of-network coverage (or very minimal) for care received.

Point of Service Plan (POS) Plan – This type of plan offers more flexibility than a HMO plan, is similar to a PPO plan in that you are allowed to go to specialists without a referral from your PCP. However, you will pay a higher co-pay or coinsurance if you go to doctors that do not participate in your provider network. To help minimize costs, always try to choose or request that your PCP refers you to network providers.

Preferred Provider Organization

(PPO) Plan – This plan also provides the patient access to a network of preferred providers, however, you may visit any of them at any time without receiving a referral first. Your out-of-pocket expenses will be less if you use a provider within the plan, but if you visit a doctor that is out of network, you will be responsible for a larger portion of the cost. This type of plan is typically more expensive, but they include a larger network of doctors, including specialty doctors and frequently include providers from a national network that allows more access outside of your local area. For people who travel a lot or students who live out of the area this can be important.

