

How to Choose the Right Plan for You



There are many factors to think about when choosing a health plan for you and your family. Will you have access to your regular doctors? Will it cover the services and medications you need? And, maybe most importantly, how much will it cost?

Whether you're choosing one of the plans offered by your employer, or buying health insurance on your own, it's important to compare all of your options and get an idea of how much you will pay. Remember, your monthly premium isn't the only cost to consider. Your plan may also have deductibles, co-payments, co-insurance and other cost-

sharing features. Make sure you understand all of these before you make a decision.

So, what do you need to know before choosing a plan? Start by asking these questions:

What Types of Plans Can I Choose From?

Many insurers offer a range of different plans, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Point of Service (POS) plans or Exclusive Provider Organizations (EPOs). Each of these plans has its own structure, with different access to providers and different types of costs. You can learn more about them by reading *Alphabet Soup of Plans*.

A Note About High Deductible Health Plans

Many employers now also offer high deductible health plans (HDHPs). These plans have low monthly premiums, but in exchange, you will have to meet a higher deductible – the amount you must pay before your plan begins paying for your care. There are ways to help manage healthcare costs under these plans. Many HDHPs include special health savings accounts or health reimbursement arrangements, where you can set money aside just for your health costs. Learn more by visiting our article on HDHPs.

How Much Will I Have to Pay?

Almost every type of health plan involves “cost-sharing,” which means that you and your insurer split the cost of your care. Your share of the cost will depend on the type of plan and whether you use a provider who is in your plan's network. If you go “out-of-network” you may have more providers to choose from, but you will usually pay more.

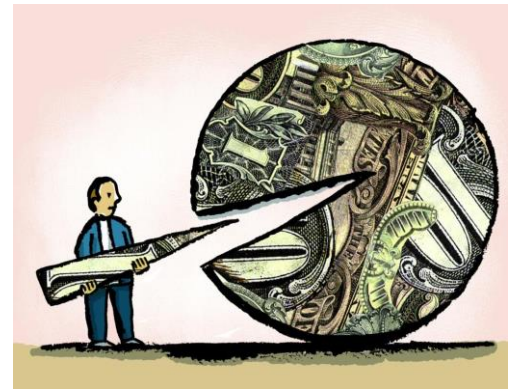
How much are the premium and deductible?

Most health plans require a premium payment. This is the amount that you pay to buy and maintain your health plan. If you have health coverage through your job, your employer may pay some, or even all, of the premium. Usually, your employer automatically deducts your share of the premium from your paycheck and forwards it to the health insurer.

Most health plans also have a deductible. This is the amount that you will need to pay out-of-pocket before your plan begins paying for services.

Keep in mind that you may have separate deductibles for different types of coverage. For example, if you meet your deductible for medical services like doctors' visits, it may not count toward your deductible for prescription drugs. Make sure to read the plan description (available from the health plan or online) so that you understand how much you may have to pay.

The premium and deductible costs are set at the beginning of each plan year, which may be different than a calendar year.



What other costs will I have?

In addition to the premium and deductible, you may have to pay:

- **Co-payments** - This is a fixed dollar amount you pay each time you visit a doctor or pick up a prescription medication. Your co-payments will be described in your health insurance policy and may be listed on your insurance card. Some plans require higher co-payments for specialists than for primary care. You might pay \$20 to visit your family doctor, but \$30 to visit a specialist. You may also have different co-payments for certain types of medications. For example, you might pay \$10 for a generic prescription, and \$25 for a brand-name.
- **Co-insurance**- After you meet your deductible, many plans also require co-insurance. With co-insurance, you pay a fixed percentage of the amount that your insurer has agreed to pay for a medical service. Your plan pays the rest. The percentage will depend on your health plan. For instance, you may pay 20% co-insurance for covered services and the plan will pay the other 80%.

What else affects my costs?

- **Allowed Charges** – This is the amount your insurer agrees to pay for a service. It includes your share of the cost, too. Providers in your plan's network have agreed to accept a certain allowed charge, or negotiated rate, for their services. For out-of-network providers, the allowed charge may be different.

It's important to understand allowed charges, because if you visit an out-of-network provider who charges more than your plan allows, you will have to pay the difference. This is known as "balance billing." And that's in addition to your deductibles, co-payments and co-insurance.

- **Out-of-Pocket Maximum** – Many plans have out-of-pocket limits. This is the maximum amount of money your insurer can require you to pay over a certain period, generally a plan year. After you reach the out-of-pocket maximum, your plan will pay the full cost for covered services up to their allowed charges. Keep in mind that you may have a different out-of-pocket maximum for in-network and out-of-network services. Also, any money you pay for services that aren't covered by your plan won't count toward your limit.
- **Limits on Services** – Some plans may limit certain types of services. For example, you may only be allowed 10 chiropractic visits per year. After that, you will have to pay the full cost of any additional visits. Since those extra visits won't be considered "covered", the amount you pay won't count toward your out-of-pocket limit.
- **Non-covered services**– Your plan may not cover some types of treatments, like cosmetic surgery or over-the-counter medications. You will have to pay the full cost. Again, since these aren't covered, the amount you pay won't count toward your out-of-pocket limit.

Meeting Your Deductible

Not all of your out-of-pocket costs will count toward your deductible. For example, co-payments usually are not counted. And, if you use an out-of-network provider, only the amount that your plan would have paid for the service counts towards your deductible.

Here's an example. Let's assume that you *have not* met your deductible and:

- o You visit an out-of-network provider who charges \$100
- o Your plan's allowed charge is \$80
- o Your co-insurance is 20%, and your plan pays 80%

First, you will need to pay the provider the full \$100, because your plan has not begun to cover services yet. But, not all of that \$100 will apply to your deductible.

If the deductible had been met, your plan would have paid \$64 (80% of the \$80 allowed charge). So in this case, only \$64 out of the \$100 you paid counts toward your deductible.

If you *have* met your deductible, your plan's share would still be \$64. You would pay \$16 (your 20% co-insurance for the \$80 allowed charge), plus \$20 (the difference between your plan's allowed charge and what the provider charged): a total of \$36.

You can learn more in our article on cost-sharing.

What if I Go Out-of-Network?

It's also important to think about whether you will stay in your plan's network, or go outside the network for care. If you choose to go out-of-network, your costs will usually be higher.

Some health plans, such as HMOs and EPOs, may not pay for any out-of-network care. You will have to pay the entire cost out of your own pocket.

Other types of plans may pay for some out-of-network care, but they use different methods to decide how much to pay. They may:

- Pay the same amount that in-network providers receive;
- Base payments on a multiple of the amount that Medicare would pay for the same service, such as 140% of the Medicare fee schedule; or
- Use Usual, Customary and Reasonable (UCR) charges. This is an amount that your plan determines is reasonable for that service in your local area. Some health plans use FAIR Health data to determine their own UCR charges, and base out-of-network reimbursement on that.
- Generally, if your plan uses the Medicare fee schedule, you will pay more in co-insurance. But to really understand how much you'll pay in total, you need to consider all of your cost-sharing – including co-pays and deductibles, too.

You can learn more by reading our article on the role of Medicare in out-of-network reimbursement, and by consulting plan documents, contacting a plan representative, or asking your employer's human resources department.

What Does the Plan Cover?

Finally, before you choose a health plan, it's important to know whether it will cover the doctors, treatments and medication you need. So, make sure you find out:

- Are all of your current doctors in the plan's network? (If not, how much of their fees will the plan cover?)
- What hospitals are your doctors affiliated with? Are these hospitals part of the plan's network, too?
- How many network providers are close to where you live and work?
- What about restrictions? Do you need referrals? Do you need to get prior authorization before getting some types of care and medication?
- Does the plan include a dental or vision plan? If not, does it offer a discount option for dental and vision care?
- Are preventive services covered at no cost to you? (Even if you have a high deductible health plan, your plan may cover services like check-ups and blood pressure screenings before you meet your deductible.)
- Will the plan cover your spouse and children? If so, how much will it cost? (States may have different rules for dependent coverage, so make sure to check the website of the National Association of Health Insurance Commissioners at www.naic.org.)
- If you are re-enrolling in a plan, have the premium and deductible gone up? Have the plan's benefits and out-of-pocket provisions changed? Do not assume that they have stayed the same.



Your Action Plan: Know the Costs and Benefits

Choosing a health plan is a big decision. Before you enroll, make sure you know what's covered, and what it costs.

- Consult each plan's description to learn about your coverage options, requirements, and limitations. These are available online, or from your employer. Ask questions if there's anything you don't understand.
- Look past the premiums. Make sure you understand *all* the cost-sharing requirements, including co-payments, co-insurance, and deductibles.
- Know the healthcare services and medications you need, and if the plan covers them.
- Find out whether your current doctors and providers are part of the plan's network. If they are not, you will have to pay more out-of-pocket.
- Learn how your plan pays for out-of-network care, so you can budget ahead if you need to go outside your network.
- Use our cost lookup tools to find out how much you might pay for out-of-network care, depending on how your plan calculates it. The FH Medical Cost Lookup lets you compare the UCR-based and Medicare-based reimbursement methods. Just select the "Compare Both" button to the right of the results page.
- Use this checklist developed by the California Department of Insurance to compare plans.
- Even if you don't get insurance through your employer, you can still find detailed information about the plans available to you. Consult <http://www.healthcare.gov/> for more information on coverage options in your state.

You can also learn more health insurance basics by consulting these Reimbursement 101 articles:

- Alphabet Soup of Plans
- Understanding High Deductible Health Plans
- Cost Sharing
- The Role of Medicare in Out-of-Network Reimbursement
- Questions to Ask Your Plan
- Questions to Ask Your Provider

And most importantly – remember that you are your own best advocate. Asking questions up front will help you find the plan that best fits your needs and your budget.

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