



# 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 health plan for your family, it's critical you know and can anticipate your family's 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 include 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 anyone in your family has high medical needs, look for a policy that has lower total cost sharing amounts when considered as a group. Keep in mind that your **actual total costs** include the **sum** of the premium, the deductible, the co-payments and coinsurance, all up to your out-of-pocket max.

## 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 a 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? (If beyond annual checkups, you might need to get a separate plan to address these services, as health plans have very limited benefits in these areas.)

## 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](http://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](http://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](http://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](http://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 have 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 specified network.

**Fee-for-Service (FFS) Plan** – This plan type is not as common as the others and is sometimes referred to as an *indemnity plan*. FFS plans only pay a pre-determined percentage of what is standard pricing in the area for each service received. If you are enrolled in this plan, it is important to keep good track of your medical records, receipts and total expenses. FFS plans also will require that you meet a yearly deductible before they will begin to pay claims. These plans can pay the medical provider directly or reimburse you after you submit a claim following a visit or service.

## 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 require 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 their provider network, out-of-pocket costs, and benefit details all 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 you and your insurance company proof of a referral in order for it to be covered. There is a wide variety in provider selection for HMOs, with some with 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 plan offers a little more flexibility than an HMO if you need to visit a doctor that is not your PCP. You are able to visit a doctor without engaging your PCP first, but it may impact your out-of-pocket costs. If your PCP makes a referral to a specialist provider, they will likely make them to doctors within your network. However, if they do not, it is likely you will pay a higher co-pay or coinsurance. To help minimize costs, always request that the doctor makes the recommendation within your network if available.

### 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 referrals 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 still receive some reimbursement from the plan. 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 frequent travelers or those with students out of the area, this can be important.

