



# WHICH HEALTH PLAN IS RIGHT FOR ME?

Every fall during open enrollment, millions of Americans select their health insurance coverage for the following year. Whether they obtain health insurance through their employer, or purchase it on the health insurance exchange, many people do not fully understand the differences between plans. This guide is designed to help you avoid unexpected health care costs by making a more informed decision.

TODAY, WHEN CONSUMERS ARE ASKED TO SHARE MORE IN THE COST OF THEIR CARE, YOUR HEALTH PLAN CHOICE IS MORE IMPORTANT THAN EVER.



In the pages that follow, you will find helpful definitions of health insurance terms and examples of how much coverage your monthly premium will buy. You will also discover ways to determine the amount of coverage you might need.

This guide is for **informational** purposes only and is not **meant** to substitute for the advice provided by a benefits professional.

# YOUR HEALTH INSURANCE GLOSSARY



Use this glossary to learn what different health insurance terms mean and how they affect cost and coverage.

## Premiums

The premium is a set amount that you pay each month for your coverage. In general, higher premium plans cover more of the cost of your health care.

## Deductibles

The deductible is the amount of money you have to pay for health care services until your insurance plan begins to pay. Lower-premium plans have higher deductibles that can catch consumers off-guard when they are sick or injured.

## Copay

A copay is a set amount you are expected to pay for a medical service when you are sick or injured, after you meet your deductible. You know ahead of time exactly how much you will pay.

## Co-insurance

With co-insurance, you are expected to pay a percentage of the cost of health care services when you are sick or injured. If your co-insurance is 50 percent and your bill is \$200, you will be asked to pay \$100. If the bill is \$500, you will be asked to pay \$250.

## Maximum out-of-pocket limit

The maximum out-of-pocket limit is the most you will have to pay in a year. After that, the health plan pays 100 percent of the cost. All the money you pay toward your deductible and copays or co-insurance counts toward that maximum.

## High-deductible health plan

A high-deductible health plan (HDHP) is a health insurance plan with lower premiums and higher deductibles than a traditional health plan. Minimum HDHP deductibles are set by the IRS and must be at least \$1,300 for single coverage and \$2,600 for family coverage in 2017.

# A HIGH-DEDUCTIBLE HEALTH PLAN: Savings Now, but Higher Costs Later?



**M**ore and more consumers are purchasing High-Deductible Health Plans (HDHPs) because they have low monthly premiums. (A deductible is the amount you have to pay for health care services before your insurance kicks in.) In general, consumers who choose HDHPs pay less each month for their premium, but are expected to shoulder more of the cost of care they receive.

HDHPs require consumers to pay at least a \$1,300 deductible for single coverage and \$2,600 for family coverage. It also is not unusual for HDHPs to require patients to pay 50 percent of the bill after they meet their deductibles for health care services, whether it is provided in a doctor's office or in a hospital.

Yet many people don't worry about the deductible because it's something they don't have to pay upfront. They also may not pay attention to how much they will have to pay even after they meet their deductible.

That's why it pays to look beyond the premium in figuring out how much you might pay for health insurance and health services each year. A lower premium may not be a bargain after all.

**ASK YOURSELF,  
"IF I AM HOSPITALIZED,  
HOW WOULD I PAY MY  
DEDUCTIBLE?  
MY CO-INSURANCE?"**

# WHO IS IN YOUR HEALTH PLAN NETWORK?



## Another factor to consider is your health plan's provider network.

Each plan contracts with specific physician practices, hospitals, and health care service providers who agree to provide care to plan members at a certain rate. These providers are considered **in-network**. Providers that do not sign a contract with the plan are considered **out-of-network**.

Many health plans—especially HDHPs—will not cover any of the cost of out-of-network care except for emergency care. Anything you pay out-of-pocket for out-of-network care will not count toward your deductible or maximum out-of-pocket limit.

To save money, lower-premium plans often have a narrow choice of doctors in their networks, so check to see if your doctor is in-network or not. Networks change each year, so even if your doctor was in-network in 2016, your doctor may be out-of-network in 2017.

## Provider Network Glossary

### HMO

A Health Maintenance Organization (HMO) contracts with a network of physicians, hospitals, and other health care providers who have signed contracts to provide care to the HMO's members. HMOs require you to have a primary care physician to manage your care. You generally need a referral from your primary care physician before you can see a specialist. HMOs typically do not cover non-emergency out-of-network care.

### PPO

A Preferred Provider Organization (PPO) contracts with a network of health care providers like an HMO, but you do not need a referral to see a specialist. A PPO may or may not cover non-emergency out-of-network care, albeit at a lower rate.

### EPO

An Exclusive Provider Organization (EPO) is similar to an HMO, but may not require a referral from your primary care provider to see a specialist. EPOs generally do not offer out-of-network coverage except for emergency care.

### POS

Point of Service (POS) plans are a cross between HMOs and PPOs. Like an HMO, a POS plan requires its members to coordinate care through a primary care physician. Like a PPO, a POS plan will cover out-of-network care, but you will have to pay a greater share of the cost. However, if your primary care physician refers you to an out-of-network specialist, the plan will cover the cost of care.

# HOW MUCH COVERAGE WILL I NEED?



**It's hard to predict how much medical care you'll need each year. Here are important things to consider.**

- If you have a chronic illness such as diabetes or heart disease and visit the doctor frequently, you may want to pay a higher monthly premium so your insurance will cover more of your costs.
- If you are generally healthy, you may be okay with a less comprehensive plan. It's a good idea to go for a physical so your doctor can assess your health risk. The doctor can check for conditions that may not have clear symptoms, such as hypertension or diabetes. Early detection can prevent future complications—and the Affordable Care Act requires all health plans to cover 100 percent of annual physicals and screenings.
- If you cannot afford to pay a high deductible or out-of-pocket maximum, buy a higher-premium plan that will cover more of your costs. The real purpose of health insurance is to protect you from financial risk in case of an unforeseen serious illness or injury.

## Planning for the Future



### RAINY DAY FUND HELP

Putting money away “just in case” will help you worry less and focus more on healing if you get sick or injured. You may be able to put away money on a pre-tax basis. Check with your financial advisor, accountant, or employer to find out if you are eligible for either of the options below.



### HEALTH SAVINGS ACCOUNT

Individuals may start a Health Savings Account (HSA) through their bank or other financial institution, but only if they are covered by a high-deductible health plan (HDHP). Money you do not use during the year can be used in later years.



### FLEXIBLE SPENDING ARRANGEMENT

Many employers offer employees a Flexible Spending Arrangement (FSA) in which the employee can contribute pre-tax dollars to pay for qualified medical expenses. FSAs are “use it or lose it” accounts. Any money not spent during the year will be forfeited. However, the IRS now allows a two-and-a-half-month grace period to use the funds after the plan year.

