Questions to Consider for Health Insurance

Getting health insurance is an important part of transitioning to adult care. Different types of health insurance plans offer different ways for you to get health care, and helps pay for your medical needs. At the bottom are definitions of terms you will read in this handout. They are good to know when signing up for and talking with others about your health insurance.

Below are some things to consider when selecting a health insurance plan:

Cost (Paying for health insurance):

Consider the amount you can afford to pay monthly for your premium and out-of-pocket expenses (deductible, co-insurance, out-of-pocket limit, and copays).

- What will be my monthly premium payment for health insurance coverage?
- How much will I be able to spend on my health insurance premium?
- Is there a deductible I must pay before my insurance will begin to pay for my healthcare needs?
- After I pay my deductible, what will my health insurance pay for my healthcare needs?
- Is there a yearly out-of-pocket maximum?
- What will I pay for an appointment with my primary care physician?
- What will I pay for an appointment with my specialty physician?
- Will I pay extra to see a physician outside the network?

Coverage (Identifying amount of benefits needed):

Make sure that your health insurance will cover your medical needs.

- Are pharmacy benefits part of the medical deductible, co-insurance, or out-of-pocket maximum?
- Is dental and vision covered under my health insurance plan?
- Does my health insurance have coverage for durable medical equipment (DME) such as wheelchairs, walkers, crutches…?
- Does my health insurance have any limitations?
    - How many times can I see my primary care physician a year?
    - Is there a maximum amount of prescriptions I can receive?

Types of Insurance Plans

- **Exclusive Provider Organization (EPO):** A managed care plan where services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency).
- **Health Maintenance Organization (HMO):** A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally will not 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 integrated care and focus on prevention and wellness.
- **Point of Service (POS):** A type of plan where you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans require you to get a referral from your primary care doctor in order to see a specialist.
- **Preferred Provider Organization (PPO):** A type of health plan where you pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

Source:
https://www.healthcare.gov/choose-a-plan/plan-types/

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Access to Care:

It is important to identify in-network physicians that will care for your specific medical needs to avoid out-of-network costs. Not all of your physicians may be in-network with your health insurance plan.

- Are my current physicians in-network?
- What hospitals are in-network in my area?
- Is it possible to stay with my specialist, if they are out-of-network with my health insurance plan?
    - If so, what will I pay for my appointment with my specialist?
- Do I need a referral from my primary doctor to see a specialist?
- Are my current prescriptions covered?
- What hospitals are in-network in my area?
- Is it possible to stay with my specialist, if they are out-of-network with my health insurance plan?
- If so, what will I pay for my appointment with my specialist?
- Do I need a referral from my primary doctor to see a specialist?
- Are my current prescriptions covered?

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Key Terms

Below are common terms that may be used by your insurance:

Appeal: the action taken if you disagree with a coverage or payment decision by your health insurance or plan.

Benefits or Covered Services: the services or supplies your health insurance or plan agrees to cover. Covered benefits and non-covered benefits vary from plan to plan.

Co-Insurance: a percentage you may be required to pay as a shared cost between you and your health insurance or plan after you pay any deductible.

Co-Payments: a set amount paid by you to a health care provider for a medical service or supply.

Deductible: amount you owe for health care services before your health insurance or plan begins to pay.

Excluded Services: health care services that your health insurance or plan does not pay for.

Explanation of Benefits (EOB): a summary of health care charges that your health insurance or plan sends you after you see a doctor or get a service. This is not a bill.

Formulary (drug list): list of prescription drugs covered by a prescription drug plan.

In-Network: a provider who contracts with your health insurance or plan to provide health care services.

Out-of-Network: a provider that does NOT have a contract with your health insurance or plan to provide services to you. You will pay more see them.

Out-of-Pocket Maximum: the most you will be required to pay (usually per year) before your health insurance or plan starts to pay 100% for your health care benefits. It is a set amount by your health insurance or plan.

Preauthorization (prior authorization): an authorization required from health insurance or plan before you receive treatment for certain services.

Premium: the amount you pay a health insurance or plan each month for health or prescription drug coverage.

Primary Care Physician: a doctor you see first for most health problems. He or she may send you to another doctor who focuses in a certain medical area.

Specialist: a doctor that focuses on a specific area of medicine.

Source: https://marketplace.cms.gov/outreach-and-education/downloads/c2c-roadmap.pdf

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