

Alphabet Soup of Health Plans

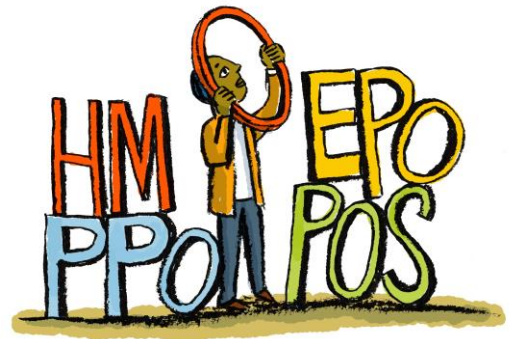
Health Plans: Choosing the Type That's Right for You

When you log on to your insurer's website, or look through their brochures, there are probably a variety of plan types to choose from – HMO, PPO, EPO, POS. Many insurers offer a range of these different products. Each of these types of plans is structured differently, and your costs will be different for each one.

Health Maintenance Organization (HMO)

What is it?

In an HMO, you get all your care from providers in your plan's network. When you join an HMO, you select a Primary Care Physician (PCP) who coordinates your care, and refers you to specialists if needed. When you need care, you must visit your PCP first. There's generally no paperwork for you in an HMO. You simply pay your co-payment up front when you visit your doctor, and you are not responsible for any other costs.



What are my costs?

In an HMO, you generally only have a co-pay. Most HMOs do not require a deductible, so your out-of-pocket costs are usually lower in an HMO than with other plans, as long as you stay in-network.

If you get care out-of-network, you will usually have to pay the full cost of the doctor's visit or service. And that may become very expensive. So, if you choose an HMO, it's important to make sure the doctors you need are in your plan's network first. You should make sure that the hospitals your doctors are affiliated with are in the plan's network, too.

What is the network like?

HMO networks are typically limited to a specific geographic region. Your HMO may have a limited network (a "staff model" where they employ their own doctors, or a "group model" where they contract with one specific group practice). Or, they may have a wider network (a "network" or "individual practice association" model, where they contract with many different providers in many different practices). Make sure you know whether your HMO has the range of providers you will need to stay in-network for your care.

Why join an HMO?

An HMO may be right for you if you want lower out-of-pocket costs, less paperwork, and if your doctors already participate in the network. If you have to go out-of-network, your costs can add up fast. It's also important to remember that since an HMO's network is limited to a specific area, it may not be right for you if you spend part of the year living somewhere else.

Preferred Provider Organization (PPO)

What is it?

In a PPO, you have the choice of using providers inside or outside of your plan's network. You don't need to choose a primary care physician, or get referrals to see specialists. But, if you do go out-of-network, your costs will be higher. You won't have to pay the full cost of your care, but you'll pay a bigger share.

There's not much paperwork in a PPO if you stay in-network. You simply pay your co-payment or co-insurance up front when you visit your doctor, and your doctor in turn sends claims right to your insurer.

What are my costs?

When you stay in your provider network, you will generally have to pay either a set co-payment, or co-insurance, which is a percentage of the cost of the visit. You will pay this amount up front when you visit your provider.

When you go out-of-network, it's a different story. You will usually have to pay:



- A higher deductible than for in-network services
- A percentage (co-insurance) of the out-of-network "allowed amount" for the service you need. This percentage may be higher than for in-network services. For instance, instead of paying 20% of the allowed amount, you might have to pay 30% PLUS the full difference between the allowed amount and your provider's actual charge, which could be much higher – and will almost certainly be higher than your plan's contracted rate for in-network care.

What is the network like?

A PPO will give you a lot of choice for your care. Most PPOs contract with a wide range of doctors, specialists, hospitals and other providers.

Why join a PPO?

You may want to consider a PPO if you want the flexibility to visit a range of different providers without getting a referral first.

Point of Service Plan (POS)

What is it?

A POS plan is a combination of an HMO and PPO. You decide whether to stay in your network or go outside of it at the time you need care (the "point of service"). With a POS plan, you select a Primary Care Physician (PCP) who coordinates your care, and refers you to specialists if needed. When you need medical attention, you visit your PCP first, and he or she can refer you either in- or out-of-network. But, if you do go out-of-network, your costs will be higher. You won't have to pay the full cost of your care, but you'll pay a bigger share.

There's not much paperwork in a POS if you stay in-network. You simply pay your co-payment or co-insurance up front when you visit your doctor, and your doctor in turn sends claims right to your insurer. But, if you go out-of-network, you'll need to pay the provider in full yourself, and then submit the claim to your insurer to be reimbursed.

What are my costs?

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What is the network like?

In network, a POS plan is like an HMO, so the network options would often be similar to those for HMOs.

Why join a POS Plan?

You may want to consider a POS if you generally want lower costs up front and less paperwork, but you also want the option of going out-of-network if you need to. A POS may also be a good choice if you spend part of the year living somewhere else.

Exclusive Provider Organization (EPO)

Another type of plan you may see is the EPO. It functions like a PPO, but with one important difference – if you go outside the network for your care, you will generally have to pay *the full cost* of the service yourself.

If you join an EPO, it's very important to make sure the providers you need are in the network first – just like an HMO.

Tiered Plans: Another Cost to Consider

Even when you stay in your plan’s network, you may have to pay more to see some providers. That’s because some plans assign their providers to “tiers” to encourage members to use the most cost-effective providers. This is similar to the way many prescription plans are set up, where you have a lower co-pay for generic medications, and a higher co-pay for brand-name drugs.

With a tiered system, you may pay a \$25 co-payment to see a doctor in Tier 1, \$35 for Tier 2, and \$45 for Tier 3. So, when you are looking at plans, make sure you ask about whether the plan has tiers, and which level your doctors fall into.

What about Emergencies?

What happens if you suffer a heart attack? Waiting to get care in an emergency is dangerous and can even be life-threatening. So, many plans cover some portion of emergency care no matter where you are, even out of their network area. Once your condition is stable, you will generally be moved to an in-network provider for follow-up care.

But remember, that only applies to *real emergencies*. You should never go to the emergency room for routine care, like check-ups or vaccinations. Emergency room visits cost more than regular doctor's visits, and insurers often won't pay certain emergency costs if it's not a true emergency. That means you'll be left with a big bill. Plus, you'll get better, more personalized care from your own doctor, and you won't have to wait for hours in the ER.

If you're not sure what constitutes an emergency or what emergency costs are covered, ask your insurer or check your plan documents.

Your Action Plan: Find a Plan That Fits Your Needs

When you choose a health plan, your goal should be to stay in-network for your care. That's the best way to control your out-of-pocket costs. So, you need to be sure that the type of plan you choose has the providers that you need.

Before choosing a plan, ask your doctor or insurer these questions:

- Are all your current doctors in the network?
- What hospitals are your doctors affiliated with? Are they in the network, too?
- If the plan is "tiered", what tier are your doctors and their affiliated hospitals in? How much will you have to pay for providers in each tier?
- 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?

Every plan is required to provide you with a complete plan description outlining all of its coverage, requirements and limitations. These are often available on your insurer's website. Read it carefully, and ask questions if there's anything you don't understand.

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

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