

Things to Consider When Choosing Your Health Coverage

Choosing a health insurance plan can feel like an overwhelming task. Here are five things to keep in mind when choosing health coverage for you and your family. For specific information on plan components, see your plan's Summary of **Benefits**ⁱ and Coverage (available upon request from your Benefits Specialist).

1. Type of Plan and Provider Network

Do the health care providersⁱⁱ, hospitals, and pharmacies you prefer fall within the plan's networkⁱⁱⁱ?

- It is important to remember that in-network services and medicines are covered under a plan, while out-of-network services and medicines may require additional out-of-pocket costs or may not be covered at all. Importantly, out-of-pocket costs for out-of-network services may not count toward a plan's out-of-pocket maximum. Check to see if your preferred primary care or specialist provider and the pharmacy near your home are included in the plan's network.

2. Premiums

How much will you pay per month for coverage?

- Premiums are the amount you pay an insurance company for coverage, whether you use medical and pharmacy services. **Premiums**^{iv} are usually paid monthly, and if you stop making payments, you are at risk of losing your coverage. Keep in mind that these are not the only costs associated with coverage. You will also be responsible for paying **deductibles**^v and for **cost sharing**^{vi}, for example, co-pays and **coinsurance**^{vii}, for most health care services and treatments. (See descriptions below)

3. Deductibles

What is the amount you must pay out of pocket before your coverage kicks in?

- For example, if your deductible is \$1,000, your health plan will not pay most expenses until you have spent \$1,000 on expenses out of pocket. Out-of-pocket costs may include specialist visits, procedure fees, and in some cases even prescriptions. Certain preventive services, such as approved cancer screenings and vaccines, are typically covered with no cost sharing before you reach your deductible. Patients who select a plan with a high deductible will most likely have a lower monthly premium, while lower deductibles often have higher monthly premiums. Insurers increasingly require a deductible to be met before covering most medical or pharmacy services. Be sure to check with your insurer to know if your plan has either a single, **combined deductible**^{viii} for medical and pharmacy services or a separate deductible for prescriptions to know how much you will have to pay before medicines are covered.

4. Co-pay or Coinsurance

Are you aware of other costs that you may be required to pay to access care?

- Do not forget you may be responsible for other out-of-pocket expenses even after you reach your deductible. These can include:
 - Coinsurance - a percentage of costs you must pay for a medicine or service, or
 - Co-pay - flat fees you are required to pay for prescriptions or covered services (often listed on the back of your insurance card)

5. Coverage of Medicines

Are your regular prescriptions covered by your insurance plan?

- Each insurer has a **formulary**^{ix} (list of medicines) covered by the plan. If a medicine is not on the formulary, it may not be covered, and patients will then have to go through a potentially lengthy process to obtain coverage. The list of covered medicines is also divided into **tiers**^x, which determine how much of a co-pay or coinsurance you may have to pay. Make a list of your current medicines and compare it to the plan's formulary to make sure your medicines are covered, and you understand the out-of-pocket costs that may be associated with them.

ⁱ Health care items or services covered by health plans. Examples include emergency services, hospitalization, prescription drugs, laboratory services and wellness visits.

ⁱⁱ A person or entity that provides health care services. This could be a doctor, nurse, physician's assistant, or other health care service provider. Also see Network.

ⁱⁱⁱ A network includes the facilities, providers, and suppliers that a health insurer or plan has contracted with to provide health care services to patients enrolled in their plans.

^{iv} The amount paid for health insurance coverage, usually paid monthly, quarterly, or yearly. Premium payments vary based on the type of coverage and cost sharing a plan requires. Premiums do not count toward a deductible or toward the maximum out-of-pocket limit.

^v The amount patients must pay annually with their own money (out of pocket) before a health plan will pay for most non-preventive health care expenses. This amount does not include premiums. For example, if a deductible is \$1,000, the health plan will not pay for most items or services until a patient pays \$1,000 out of pocket. Sometimes plans exempt certain costs, such as some or all prescription drugs, from the deductible. In most cases, preventive services are covered with no cost sharing, even if you have not reached your deductible. The deductible typically resets annually.

^{vi} The amount insurance plans require patients to pay out of their own pockets. For example, cost sharing includes co-pays, coinsurance, and deductibles. Cost sharing does not include premiums.

^{vii} Coinsurance is a percentage of costs a patient is responsible for paying with his or her own money (out of pocket). Health insurance plans specify what this percentage will be for a variety of health-related services, such as a specialist visit, emergency room visit or prescription medications. Because coinsurance is a percentage of total costs, it can be difficult to estimate and plan for in advance.

^{viii} A deductible – the total amount a patient must pay out of pocket annually before the health plan begins to pay – that includes both medical care and prescription medicines. This amount does not include premiums. For example, if a deductible is \$1,000, the health plan will not pay anything for most non-preventive health care until a patient pays \$1,000 out of pocket. Also see Deductible.

^{ix} The list of prescription medicines covered by a health insurance plan. A non-covered medicine is not included in the list of prescription drugs covered by an insurer. For non-covered medicines, patients must pay for the cost of the medicine or go through an exceptions process to get it covered. Also see Drug List or Tiers.

^x The list of medicines covered by a health insurance plan is often broken down into tiers – usually three or four. Lower tiers (Tier 1 or Tier 2) typically require co-payments, which are fixed dollar amounts, typically ranging from \$10 to \$50. Higher tiers (Tier 3 or Tier 4) are more likely to require coinsurance, which is a percentage of the cost of a medicine. This amount varies based on the cost of the medicine and, as a result, is harder to predict. Which tier a medicine falls under is included on a plan formulary. Also see Formulary or Drug List.