CALLAN CAPITAL

TOOLS FOR FINDING A HEALTH INSURANCE PLAN

For you and your family

+ TOOLS FOR FINDING A HEALTH INSURANCE PLAN

If you have lost health insurance coverage due to early retirement, selling your business or because of a change in family circumstances, finding coverage on your own can be stressful. There are many considerations when looking for a health care plan—this guide will help you navigate through the health care marketplace and help you find the best plan for your needs.

+ WHEN TO LOOK FOR A PLAN

First, it's important to note that unless you qualify for a Special Enrollment period, you will have to sign up during the Open Enrollment Period each year. Most states have open enrollment from November 15th through December 15th, the year before coverage begins. You may be eligible to enroll during a Special Enrollment Period if you lost coverage due to leaving your employer, selling your business, divorce, moving to a new area or other major changes in circumstances. Generally, you have 60 days from the date of the qualifying event to choose a new plan. If you miss this window, you may have to wait until open enrollment at the end of the year.

+ WHERE TO FIND A PLAN

Anyone can find a health care plan on the Healthcare Marketplace https://www.healthcare.gov/. Each state has their own marketplace established under the Affordable Care Act. People with lower incomes may be eligible for a subsidy for marketplace plans, but plans are available to anyone at full price. The marketplace allows you to compare and contrast available plans in your area side-by-side. You may also buy a policy through an individual provider or health care broker, however, these plans may not meet the minimum requirements of the ACA.

+ DIFFERENT TYPES OF PLANS

When choosing a plan, it's important to know how different types of plans are defined. There are four major types of health insurance plans—HMO, PPO, EPO and POS. HMOs and POS plans require you to choose a Primary Care Physician that is in that health care plan's network of providers. You are generally required to obtain a referral from that Primary Care Physician before you can see a specialist. Many people want the freedom to see a specialist without first having to see their primary physician, but these plans tend to have lower costs overall. The main difference between a HMO and a POS plan is that a POS plan allows you to see doctors who are out-of-network at an additional cost, whereas an HMO requires you to stay in-network, except in the case of emergency care. A PPO and an EPO are similar in that you do not need to have a referral to see a specialist, you can see a specialist directly. These plans are typically more expensive than an HMO or POS plan. An EPO requires you stay in-network, except for emergency care, whereas a PPO will allow you to see providers out of your network at an additional cost.

+ COSTS ASSOCIATED WITH EACH PLAN

When comparing plans, look for a Summary of Benefits. The summary of benefits will display the various costs and coverages associated with each plan. Your health care costs will consist of several parts—your premium, deductible, copayments, coinsurance and out-of-pocket costs.

Your premium is the amount you pay every month to have the insurance plan.
Your deductible is the amount you must pay for your own health care before your health insurance will begin to pay towards your health care costs. Some plans have a $0 deductible and kick in immediately. Other plans have a high deductible, such as $4,000, where you would have to spend $4,000 towards your health care before your insurance will pay. The deducible resets every year.
Your copayment is a flat charge you have to pay for different types of services you use. For example, you may have to pay $45 every time you see your doctor.
Your coinsurance is usually a percentage of larger health care services that you share with your insurance. If you have a knee surgery and your coinsurance is 30%, you pay 30% of the total cost of that health care service and your health insurance pays the other 70%.
Your out-of-pocket expense is the amount you pay towards your health care that is covered under your insurance but that your insurance does not pay for (not including premiums). Many plans have an Out-of-Pocket Maximum, where they cap the amount you would have to pay each year out of your own pocket.
Here's an example of how all these costs work together:

Let's say you need shoulder surgery on January 1 that costs of $40,000. You have a plan with the following benefits:
Deductible: $2,000
Coinsurance: 20%
Out-of-pocket maximum: $5,000

First you need to meet your annual deductible. You pay the first $2,000 of covered medical expenses (your deductible). Next, your coinsurance of 20% on the rest of the costs ($38,000) comes to $7,600.
Your total costs would be $9,600 (deductible plus coinsurance). But, you have an out-of-pocket maximum of $5,000. Your insurance company pays all covered costs above $5,000 — for this surgery and any covered care you get for the rest of the plan year. You end up paying $5,000 for this surgery (maxing out your out-of-pocket expenses and paying your deductible for the year) and your insurance pays the remaining $35,000.

+ IN-NETWORK AND OUT OF NETWORK

If you choose a plan like a PPO or a POS, that allows you to go "out-of-network", there are a few more points to consider. Providers that are "in-network" are providers that accept your insurance's negotiated rate for services, so your costs are predictable. When you go "out-of-network" to see a provider, that provider does not have negotiated rates with your insurance plan, and most often, will charge more than in-network providers. You will end up paying any amount that doctor charges above what your insurance covers. If you choose a plan that does not cover out-of-network providers such as an HMO or EPO, you pay for 100% of any out-of-network charges.

If you have a doctor you would like to keep working with, find out if he or she is in-network with the plans you are considering. Don't take the word of the insurance company, providers change what insurance plans they work with and your insurance may not have the most up-to-date information. Instead, call your doctor and ask: "Will you accept this plan next year?"

+ IMPORTANT REMINDERS

Plan costs and plan coverage have an inverse relationship. Plans with higher costs generally cover more and plans with lower costs will cover less. However, just like car insurance, if you don't make a lot of claims on your insurance, choosing a plan with higher deductibles and lower premiums can make sense.

A plan that pays more of your medical costs, but has higher monthly premiums, is better if:

- You see a doctor frequently
- You often need emergency care
- You have expensive prescriptions
- You plan to have a baby or you have small children

A plan with high out-of-pocket costs and low monthly premiums, is better if:

- You can't afford the higher monthly premiums for a plan with lower out-of-pocket costs
- You are in good health and rarely see a doctor

Make sure you shop around and compare plans. When choosing a plan, you should look at the whole plan: the type of plan, the deductibles, coinsurance, out-of-pocket maximums, which doctors are in-network and the plan premiums.

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