Choosing Health Insurance That's Best for You and Your Family

This information explains types of health insurance plans. It can help you decide what plan is best for you and your family.

What is health insurance?

Health insurance covers some or all the costs for going to a healthcare provider or hospital, or prescription medications. Health insurance, also called a health plan, protects you from the high costs of health care services when you're sick. It also can help pay for services and wellness programs to help you stay healthy. Depending on the kind of health plan you have, it can cover you, your family, or both.

What are the types of health plans?

There are many kinds of health plans.

Preferred Provider Organization (PPO)

These plans let you see health care providers who are in-network and out-of-network.

- In-network means a healthcare provider, hospital, or pharmacy that has a contract with your insurer. You pay less when you go to an in-network provider.
- Out-of-network means a healthcare provider does not have a contract with your insurer. It often costs you more money to go to a healthcare provider or hospital out of your network.

Exclusive Provider Organization (EPO)

These plans offer a large network of in-network healthcare providers.

- Your healthcare services are covered only if you go to a provider or hospital in the plan's network.
- This plan only covers out-of-network care in an emergency.

Point of Service (POS)

Point of Service health plans offer a smaller network of healthcare providers, and you pay to go to them.

- It may cost you more money to see out-of-network providers. You must choose a primary care provider (PCP).
- You must get a referral from your PCP for visits to a provider with special training in a health condition (called a specialist).

Health Maintenance Organization (HMO)

These are plans that only let you see in-network providers. You often need a referral from your primary care provider to go to a specialist.

Medicare

Medicare is the federal public health insurance plan. This plan is available to you if you're age 65 or older or have certain kinds of disability.

- There are different parts to Medicare.
- Each part pays for different kinds of health benefits.

Medicaid

Medicaid is a public program for people who make less than a certain amount of money.

- The government in your state decides how to provide healthcare services to people who have a Medicaid plan.

Actions to take when you're ready

Apply for health insurance

- Your job may offer health insurance benefits. You can enroll in a plan during the annual Open Enrollment season. You may also be able to join if you have made a big change in your life, like getting married or adopting a baby.
- If your job does not offer health insurance, visit your state's department of health website to learn more about getting covered. For example, in New York you can find health plans on the New York State of Health website: **nystateofhealth.ny.gov**

Memorial Sloan Kettering Cancer Center

Your Guide to Health Insurance: What Common Words Mean

Health insurance protects you from the high costs of medical bills. With insurance, you do not need to worry about paying for medical care when you need it.

Provider Networks

Some insurance plans will have a list of healthcare providers and hospitals you will choose from. This is called the provider network.

Healthcare providers in the provider network are called in-network providers. If you go to in-network providers, you will only need to pay the copayment and coinsurance out of your own pocket.

Healthcare providers who are not in your plan's provider network are called out-of-network providers. If you visit a healthcare provider out-of-network, your insurance may pay something but it will be more expensive for you.

Health Insurance Plans

There are different types of health insurance plans.

- **Health Maintenance Organizations** (HMOs) are plans that only let you see in-network providers. An HMO usually makes you get a referral from your primary care provider (PCP) to see a different kind of provider (called a specialist). Specialists are experts in caring for people with specific conditions, such as heart disease, brain disorders, and cancer.
- **Preferred Provider Organizations** (PPOs) are plans that let you see providers who are in-network or out-of-network.
- **Indemnity Plans** are plans where you pay some of the costs of healthcare. Your insurance pays the rest. These plans are also called fee-for-service.
- **Medicaid** is a free, public program for people who make below a certain amount of money.
  - Medicaid plans can be straight Medicaid (also called fee-for-service Medicaid). Or they can be a Managed Care Plan (MCP) to provide you with care at low cost.

Prescriptions

A prescription is a written or electronic order from your healthcare provider. It tells your pharmacist to provide you with specific medications. Not all drugs will be paid by your insurance plan. Check with your insurance or ask your pharmacy about which drugs are covered.

A formulary is a list of drugs that your insurance plan will pay for. These also are called preferred drugs.

You may hear drugs being described in 2 forms.

- **Generic drugs** have exactly the same active ingredient, dosage, directions, and strength as brand name drugs. But they do not have the name of a brand. Generic drugs are named after their active ingredient.
  - **Ibuprofen** is the generic name for Advil.
- **Brand name** drugs are the same as generic drugs. They cost more because they have the name of a brand.
  - **Advil** is the brand name of Ibuprofen.

What you pay for a drug depends on its level (or tier) on the formulary:

Tier 1 drugs are generic drugs, and usually the cheapest for you.

Tier 2 drugs are brand name drugs. They usually are given to you when the generic is not available.

Tier 3 drugs are not on the formulary. Your insurance plan only will pay for them if a healthcare provider says you need them.

Memorial Sloan Kettering Cancer Center

If you think you were charged for something that your insurance plan should pay for, call your provider's office. Ask for an explanation. After speaking with them, you may still think your insurance plan should pay. If so, call the Member Services number on the back of your insurance card to file a complaint. A complaint is sometimes called an appeal or grievance. Member Services may ask you to confirm some information. This includes your name, date of birth, and the ID number on your insurance card.

There are some important words you should know that can help to better understand insurance. Here is a list of the words and their meaning.

A premium is what you pay your insurance company every month to have the insurance.

A deductible is what you must pay before your insurance plan starts to pay for healthcare services.

A copayment is what you pay on your own at every medical visit.

Coinsurance is when your insurance plan pays a part of your medical bill and you pay the other part.

An out-of-pocket maximum is the highest amount you will ever have to pay on your own for health services.

A yearly or lifetime limit is the highest amount your insurance plan will ever pay (every year or during your lifetime).

Cost-sharing is when your insurance plan does not cover the whole medical bill. You pay for the part it does not cover.

Prior authorization is when your insurance plan agrees to pay for a drug or treatment. You or your healthcare provider must call the plan to ask for prior authorization, based on your medical needs.

An explanation of benefits (EOB) is a form that tells you what your insurance plan paid for your medical visit. If you also must pay an amount, the EOB will tell you what you owe.

Su Guía Para el Seguro de Salud: Qué Significan las Palabras Comunes

El seguro de salud lo protege de los altos costos de las facturas médicas. Con el seguro, no necesita preocuparse por pagar la atención médica cuando la necesite.

Redes de Proveedores

Algunos planes de seguro tendrán una lista de proveedores de atención médica y hospitales entre los que podrá elegir. Esto se llama la red de proveedores.

Los proveedores de atención médica en la red de proveedores se denominan proveedores dentro de la red. Si acude a proveedores dentro de la red, solo deberá pagar el copago y el coseguro de su propio bolsillo.

Los proveedores de atención médica que no están en la red de proveedores de su plan se denominan proveedores fuera de la red. Si visita a un proveedor de atención médica fuera de la red, es posible que su seguro pague algo, pero será más costoso para usted.

Planes de Seguro de Salud

Hay diferentes tipos de planes de seguro de salud:

- **Las organizaciones para el mantenimiento de la salud** (Health Maintenance Organization; HMO, por sus siglas en inglés) son planes que solo le permiten ver proveedores dentro de la red. Una HMO por lo general le pide que obtenga una referencia (derivación, remisión) de su proveedor de atención primaria (PCP, por sus siglas en inglés) para ver a un tipo diferente de proveedor (llamado especialista). Los especialistas son expertos en la atención de personas con afecciones específicas, como enfermedades cardíacas, trastornos cerebrales y cáncer.
- **Las organizaciones de proveedores preferidos** (PPO, por siglas en inglés) son planes que le permiten ver proveedores que están dentro o fuera de la red.
- **Los planes de indemnización** son planes en los que usted paga parte de los costos de la atención médica. Su seguro paga el resto. Estos planes también se denominan pago por servicio.

Memorial Sloan Kettering Cancer Center

- **Medicaid** es un programa público y gratuito para personas que ganan menos de cierta cantidad de dinero.
  - Los planes de Medicaid pueden ser Medicaid directo (también llamado Medicaid de tarifa por servicio). O pueden ser un plan de atención administrada (MCP) para brindarle atención a bajo costo.

Recetas

Una receta es una orden escrita o electrónica de su proveedor de atención médica. La orden le dice a su farmacéutico que le proporcione medicamentos específicos. Su plan de seguros no cubrirá todos los medicamentos. Consulte con su seguro o pregunte en su farmacia qué medicamentos están cubiertos..

Un formulario es una lista de medicamentos que su plan de seguro pagará. Estos también se denominan medicamentos preferidos.

Es posible que escuche que los medicamentos se describen en 2 formas.

- **Los medicamentos genéricos** tienen exactamente el mismo ingrediente activo, dosis, instrucciones y concentración que los medicamentos de marca. Pero no tienen el nombre de una marca. Los medicamentos genéricos reciben el nombre de su ingrediente activo.
  - **Ibuprofeno** es el hombre genérico de Advil.
- **Los medicamentos de marca** son iguales a los medicamentos genéricos. Cuestan más porque tienen el nombre de una marca.
  - **Advil** es el nombre de marca del ibuprofeno.

Lo que paga por un medicamento depende de su nivel en el formulario:

Los medicamentos del **nivel 1** son medicamentos genéricos y, por lo general, son los más baratos para usted.

Los medicamentos del **nivel 2** son medicamentos de marca. Por lo general, se le administran cuando el genérico no está disponible.

Los medicamentos del **nivel 3** no están en el formulario. Su plan de seguro solo los cubrirá si un proveedor de atención médica dice que los necesita.

Si cree que le cobraron por algo que su plan de seguro debería pagar, llame al consultorio de su proveedor. Pida una explicación. Si después de hablar con ellos sigue pensando que su plan de seguro debería pagar, llame al número de servicios para miembros que se encuentra en el reverso de su tarjeta de seguro para presentar una queja. Apelación es otra palabra que se puede usar para esto y que significa queja. El servicio para miembros puede pedirle que confirme alguna información. Esto incluye su nombre, fecha de nacimiento y el número de identificación en su tarjeta de seguro.

Hay algunas palabras importantes que debe saber que lo pueden ayudar a comprender mejor los seguros. Aquí hay una lista de las palabras y su significado.

Una prima es lo que le paga a su compañía de seguros todos los meses para comprar el seguro.

Un deducible es lo que debe pagar antes de que su plan de seguro comience a pagar los servicios de atención médica.

Un copago es lo que usted paga por su cuenta en cada consulta médica.

El coseguro es cuando su plan de seguro paga una parte de su factura médica y usted paga la otra parte.

Un desembolso máximo es la cantidad más alta que tendrá que pagar usted mismo por los servicios de salud.

Un límite anual o de por vida es la cantidad más alta que pagará su plan de seguro (cada año o durante su vida).

El costo compartido es cuando su plan de seguro no cubre la totalidad de la factura médica. Usted paga por la parte que no cubre.

La autorización previa es cuando su plan de seguro acepta pagar un medicamento o tratamiento. Usted o su proveedor de atención médica deben llamar al plan para solicitar una autorización previa, según sus necesidades médicas.

Una explicación de beneficios (EOB, por siglas en inglés) es un formulario que le dice cuánto pagó su plan de seguro por su consulta médica. Si también debe pagar una cantidad, la EOB le dirá cuánto debe.