CHOOSING A HEALTH PLAN IS AN IMPORTANT DECISION. ASKING THE RIGHT QUESTIONS WILL HELP YOU MAKE AN INFORMED DECISION.

When considering a new plan, ask:

- How much do I have to pay for care? Are there deductibles, copayments, and/or a coinsurance percentage?
- Are there pre-existing conditions, limitations, or exclusions?
- What are the specific exclusions/limitations of the policy?
- Is there a maximum out-of-pocket cost?
- What is the extent of the network in size and location?
- Do I have coverage for preventive care?
- Is there a prescription drug benefit?
- Is there a mental health benefit?
- Is there a limit to the number of inpatient hospital days I am allowed?
- How do I access services?
- How do I obtain specialty care?
- Are referrals required for specialist visits?

Types of Health Insurance Plans:

**Health Maintenance Organization (HMO)**

An HMO is a type of managed care health plan consisting of a network of doctors and hospitals dedicated to providing high-quality, affordable health care. When enrolled in an HMO, a primary care physician (PCP) coordinates all of your care and refers you to network specialists when needed.

**Indemnity**

An indemnity plan is a type of health plan that allows you to choose any doctor of your choice; however, the plan only pays part of your medical bills. Your out-of-pocket costs will be higher than with a managed care plan, and you will likely be required to pay up front for services and then file for reimbursement.

**Preferred Provider Organization (PPO)**

A PPO plan is a type of managed care health plan that allows you to see any doctor of your choice, offering both in-network and out-of-network coverage. Under a PPO plan, your out-of-pocket costs will be lower when using in-network providers.

**Point-of-Service (POS)**

A POS is a type of managed care health plan that provides the same level of coverage as an HMO plan, but affords members the opportunity for greater flexibility to seek care without a referral from a PCP and/or to seek care from a physician or hospital that does not participate in your plan’s network. You will have higher out-of-pocket costs when self-referring for care and/or when using out-of-network providers.