

Choosing the Health Plan that's Right for You



About this
fact sheet

The health plans offered in your state's marketplace all cover services that fall into 10 basic categories. But each plan is slightly different. Each will cover some different services within those 10 categories, charge you different amounts for services and prescriptions, and allow you to see different doctors and hospitals. So you'll need to review each plan carefully to choose the one that best meets your needs.

1. Will health plans in the marketplace cover all of the health care services I need?

All plans will cover at least the same basic categories of services, but the services themselves can vary from one plan to another (for example, one plan covers infertility treatment as part of maternity care and another does not). Plans will also charge you different amounts for services and prescriptions.

Questions you should ask to figure out which plan is right for you:

- **Does the plan cover the specific services and prescriptions that you need?** (for example, one plan pays for dental care and one does not)
- **How many times per year will the plan pay for specific services that you need?** (for example, one plan pays for 20 physical therapy visits and another pays for 40)
- **How much will you have to pay for a specific service or prescription?** (for example, one plan charges you \$20 for each doctor visit—another charges \$10)

10 basic categories of services

- children's health care, including vision services and, in many cases, dental services
- emergency care
- hospitalizations
- laboratory services, like X-rays
- maternity and newborn care
- mental health and substance use disorder care
- outpatient care, like doctor visits and outpatient surgery
- prescription drugs
- preventive services, like immunizations and cancer screenings
- rehabilitative and habilitative care, like physical and speech therapy

- **How much do you need to pay out of your own pocket before the plan begins paying for health care services?** (for example, one plan might make you pay \$500 before it begins to pay for your care—another may make you to pay \$1,500—this amount is called a deductible)

Plans are not required to cover elective abortions. They also do not have to cover children's dental care if the marketplace sells a separate dental plan.

MORE INFORMATION



To read more about the different costs you need to think about when selecting a plan, see Families USA's *Choosing a Health Plan You Can Afford*.

2. How can I find out whether a plan covers a specific service or medicine that I need?

There are several ways you can find information about the services that a health plan covers:

- Read the **"Summary of Benefits and Coverage"** document on the marketplace website. It is a general summary of what the plan covers, without too many details.
- Review the plan's **"Evidence of Coverage"** document for more specific details. Contact the health plan to get this document.
- Check the plan's drug formulary for a list of which medicines the plan will pay for and what the copayments will be. A plan's **"Summary of Benefits and Coverage"** document (see above) on the marketplace website will tell you how to get a copy of the plan's drug formulary.
- If these documents don't clearly explain how a service is covered, **ask a plan representative for more information** (and get that information in writing if possible).

3. What if I can't find a health plan that covers prescriptions I need?

Ask your doctor if another drug that a plan covers will also work for you. If not, you and your doctor should talk to the plan about how you can get that medicine. All plans must allow you to get the prescription that you need, even if a plan doesn't normally pay for it.

4. How do I know if a plan will pay for visits to my current doctor?

Most plans work with a group of doctors (and other providers of health services, such as hospitals). This group of doctors and providers is called a “provider network.”

To pay the lowest amount for services, you need to see the doctors in your plan’s network. If you want to continue seeing your doctor, go to the marketplace website and check to see if your doctor is listed in a plan’s network. Marketplaces will have links to all plan networks.

There are two types of networks, and each has different rules about who you can see, whether you need a referral from your primary care provider to see a specialist, and how much you’ll pay. They are:

- preferred provider organizations (PPOs) or point of service (POS) plans
- health maintenance organizations (HMOs) or exclusive provider organizations (EPOs)

See the table below for more information on the different types of provider networks.

DIFFERENCES BETWEEN TYPES OF PROVIDER NETWORKS		
	Preferred Provider Organizations (PPOs) and Point of Service (POS) Plans	Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs)
Out-of-Network Coverage	Plan pays for part of the cost of health care you get from doctors that don’t accept your insurance, but you will have to pay the rest	Plan does not pay for any health care you get from doctors that don’t accept your insurance
Need referral to see a specialist?	No	Yes

Questions you should ask about a plan's provider network:

- Does the network include providers that are easy to get to?
- Does it include doctors, specialists, and hospitals that you want to go to (such as your current providers)?
- Does it include providers that speak your preferred language?
- If you have a disability, does the plan include providers that have the accessibility equipment that you need?
- Do the plan's rules about when it will cover care from an out-of-network provider or without a referral seem fair and unlikely to get in the way of getting the care you need?

Starting in 2015, quality scores for plans will also be available, so you can review the quality of care a plan provides.

