Choosing a health plan

Making it as easy as 1, 2, 3.

fallon community health plan

Developed for you by Fallon Community Health Plan

Whether you're looking for a new type of health plan, choosing your health coverage for the first time, or just reviewing your options—choosing a health plan is a big decision, and it can be confusing! There are a lot of options and a lot of information. It's important to understand what's available to you so you can pick the coverage that's right for you.

With this booklet, Fallon Community Health Plan hopes to make choosing a health plan as easy as 1, 2, 3. On the following pages, we will answer the questions below and help you identify the questions that you should ask when choosing a health plan.

1.

Can I keep my doctor?

Why provider networks are important. What to do if your doctor is not part of a plan's network and tips for finding a new provider. See page 3.

2.

How much will it cost?

The services you will have to pay for and an overview of the different types of cost-sharing. See pages 4-6.

3.

What added benefits can I get?

The various types of benefits available plus an overview of the four different types of health plans. Learn how to save money and get more out of your plan. See page 7.

Tip: Make a list of your health care needs. This will help you determine what services you receive care for most often; such as vision care, podiatry services and diabetes monitoring supplies.

1. Can I keep my doctor?

Everyone wants to have a doctor who they feel comfortable with and trust. So, when you are looking at health insurance plans, one of the first things you may consider is if your current doctor is part of the plan's provider network.

A plan's provider network is very important because it determines which doctors and facilities you can go to for care. In many cases, your health insurance plan will only cover services you receive from an "in-network" provider.

A provider network consists of doctors, hospitals, labs, high-tech imaging centers and other medical facilities that work together to provide services that keep you healthy.

If the doctor you currently see is part of the plan's provider network—that's great! If your doctor isn't part of the plan's network, you may have to look for a new one.

Looking for a provider?

- Visit your plan's Web site for provider listings and directories.
- Ask family, friends or coworkers for suggestions.
- Search for doctors, hospitals and other medical facilities that are close to your home or work.

When choosing a new physician, first check your plan's network. You may want to see if there are any who are close to your home or work, and which ones offer convenient times for you like nights or weekends. Once you choose a doctor, call their office to make sure they are accepting new patients. It's also a good idea to see what other providers are available to you, like specialists, hospitals, urgent care centers and labs.

If you aren't ready to choose a new doctor, check with the plan to see if you are able to receive services from out-of-network providers, and what your costs would be. Your out-of-pocket fees will certainly be higher to see an out-of-network provider compared to your costs for in-network care. **Please note:** Not all plans allow you to receive services from out-of-network providers.

2. How much will it cost?

When it comes to the cost of health insurance, you probably have many questions: How much does it cost for coverage? …for prescriptions? …emergency room visits? You will also want to know what types of cost-sharing payments you are responsible for under your plan's coverage. For example, do you have to pay a copayment, coinsurance and/or a deductible? These are all great questions and it's important to find out how much you are responsible to pay for health-related services.

Items and services you will pay for

The first cost you will want to consider is your **plan premium**. This is the amount you pay to be a member of a health insurance plan. This payment is often made on a weekly or monthly basis. If you receive coverage through your employer, your plan premium may be automatically deducted from your paycheck.

The next costs that you will want to consider are any items, services or care that you expect to receive on a regular basis. These could include office visits with your primary care doctor or a specialist, prescription drugs, diabetes supplies, dialysis, lab work or other medical services and supplies. Making a list of these items will help you plan your monthly and yearly out-of-pocket costs.

Fun fact: Under the Federal Health Reform Affordable Care Act, you pay $0 for one routine wellness visit per year. And women pay $0 for annual well-woman preventive care visits. Fallon Community Health Plan (FCHP) members have received this benefit since 2005—years before the Federal Health Reform Act was enacted. FCHP was the first plan in the state to offer $0 wellness visits.

There are also costs for some benefits and services that you probably can't anticipate, such as a trip to the emergency room. However, it is important to be familiar with all plan costs so you know what you will be expected to pay for items like surgery, an inpatient hospital stay, X-rays and rehabilitation services.

The costs associated with the above services should be available on your plan's Web site or in the plan's Evidence of Coverage (this may also be called a Member Handbook). Your health plan may also offer discounts or reimbursements to help "offset" some of your out-of-pocket costs. You can find more information about that in section 3 of this booklet.

How you will pay for covered items and services

In addition to your plan premium, you're responsible for the out-of-pocket costs associated with any health-related item or service that you receive. These out-of-pocket costs are called deductibles, copayments and coinsurance. Here's a brief overview of how they work:

Overview of out-of-pocket costs	
Deductibles	A deductible is the amount you must pay out of your pocket before your plan will pay for certain services. For example, if you have a $500 annual deductible, you will have to pay for the first $500 worth of designated medical services you receive each year. For more information about deductibles, refer to **FCHP's guide, *Deductibles: Making them as easy as 1, 2, 3.***
Copayments	This type of payment requires you to pay a set dollar amount for services like doctor visits, prescriptions that you fill, etc. Copayment amounts usually vary by the service provided.
Coinsurance	Coinsurance is your share of the cost for a service you receive. This is usually a percentage. For example, if your coinsurance is 20% for a doctor visit, you pay 20% of the total charges and your insurer pays 80%.

Your plan may or may not require you to pay a deductible. And, you could be responsible to pay either a copayment or coinsurance—not both. Some services may require a copayment after the deductible has been met.

Some health plans tier their providers—including physicians, high-tech imaging centers and hospitals. Your out-of-pocket costs are determined by the level, or tier, assigned to the provider from whom you receive services. Prescription drugs are also assigned tiers. Tiering allows you to have more control of your out-of-pocket expenses. *Please note: provider and prescription tiering varies by plan, so be sure to read all of your plan documents.*

3. What added benefits can I get?

Health plan benefits and coverage vary greatly. You will find that many plans cover benefits like preventive care, doctor office visits, inpatient hospital care, lab tests and radiology services. However, you may find that there are many other benefits that will be covered under some plans and not others. Therefore, it's good to have an idea of the benefits you want and need from your health plan. Some of these "added" benefits include, but are not limited to:

- Chiropractic services
- Substance abuse care/counseling
- Dental services
- Mental health care
- Health and nutrition education
- Prescription drug coverage
- Hearing exams
- Fitness class or gym membership reimbursements

Fallon Community Health Plan members get up to 40% off eyeglass frames and discounts on contact lenses, nonprescription sunglasses and laser vision correction—as part of their vision care benefit.

What is a formulary?

A formulary is a list of prescription drugs that are covered under a health plan. If you take any prescription drugs on a regular basis, you should check your plan's formulary to see if the medication is covered. Fallon Community Health Plan members can find their plan's covered prescriptions at fchp.org.

Different types of health plan options

Now that you have a better understanding about plan benefits, you may want to learn more about the different types of health plans offered. There are four different types of health insurance plans: HMOs (Health Maintenance Organizations), PPOs (Preferred Provider Organizations), POS plans (Point of Service) and Indemnity or "Fee for Service" plans. The following table provides a very brief overview of how each type of plan works.

Type of plan and brief description
HMO plans Members receive coordinated care from a network of providers who work together. This type of care usually results in lower out of pocket costs for members. For more information, refer to **FCHP's guide: *HMOs: Making them as easy as 1, 2, 3.***
PPO plans These plans typically offer the same type of coverage as an HMO but have many more doctors from whom you can receive care.
POS plans For out-of-network care, members may be responsible for filling out paperwork, sending in bills for reimbursements and keeping records of all the out-of-pocket costs that they have paid.
Indemnity/Fee-for-Service plans Members agree to pay a pre-determined percentage of the cost of health care services and the insurer pays the remaining costs. Plan costs fluctuate as the price for care is determined by individual providers.

Some health plans include a limited network. In this type of network, members receive care from a subset of the plan's network of providers. Limited networks allow insurers to control costs and pass the savings on to members.

In-network providers	Out-of-network coverage	Must elect a primary care physician	Referrals for specialty care
Yes	No	Yes	Yes
Yes	Yes, usually with higher out-of-pocket costs for members	No	No
Yes	Yes, usually with higher out-of-pocket costs for members	Yes	Yes
No	n/a	No	No

Save money and get more out of your plan!

After you determine which benefits are important to you and the type of plan you want for coverage, you should look for extra savings and benefits. These incentives can vary greatly among plans. So shop around until you find a plan that benefits you!

Here are some money-saving features you may want to look for:

- Reimbursements for healthy activities—FCHP members have one of the richest, most flexible fitness benefits in the state! Members get paid for participating in healthy activities like town and school sports, yoga and Pilates classes, memberships to the gym of their choice, new home cardiovascular equipment, weight loss programs and more!
- Discounts on acupuncture, chiropractic care and massage therapy
- Discounts on health and wellness products
- Access to medical professionals and advice outside of normal office hours
- Perks for expecting parents like a free car seat, electric breast pump and prenatal vitamins
- Savings on family activities

FCHP members have access to all of the extra savings listed above and more! To see how much you could save, call FCHP Customer Service at 1-800-868-5200 or visit us at fchp.org.

Making changes to your health care coverage

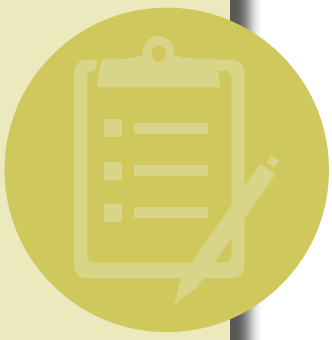
Now that you're armed with the information you need to choose a health plan, you need to find out when you are able to change your current plan. Most health plans only allow you to change your coverage or add people to your coverage during certain times. Here are some examples:

- During annual open enrollment
- If you marry or divorce
- If you have a child, through birth or adoption
- If your spouse or dependent loses other coverage (e.g., job loss)
- If a dependent child qualifies for coverage under IRS guidelines
- If you are court-ordered to cover your children or former spouse.

If you have questions about changing your health care coverage, you should contact your plan provider.

Before choosing a health plan, ask:

- ☐ Does the service area include doctors/hospitals that are close to my home/work?
- ☐ What health care services are covered?
- ☐ Is there emergency coverage when I'm away from home?
- ☐ What will my out-of-pocket costs be? Monthly? Yearly?
- ☐ Are my prescriptions covered on the plan's formulary?
- ☐ Will I get reimbursed for healthy activities?
- ☐ Do I need a referral to see a specialist?



We hope this booklet has made choosing a health plan easier to understand. When you are ready, it is a good idea to request more information about specific plans that might be right for you.

To reach Fallon Community Health Plan Customer Service, call

1-800-868-5200

(TTY users, please call TRS Relay 711.)

Fallon Community Health Plan

1-800-868-5200

(TTY users, please call TRS Relay 711.)

www.fchp.org

12-715-350 Rev. 00 12/12