**WHAT IS HEALTH INSURANCE?**

It’s a way to pay for health care. It protects you from paying the full costs of medical services when you’re injured or sick.

**NOTE:** Each health insurance plan is different and covers different medical costs. You can get health insurance from a number of sources, such as:

- Employers
- State Exchanges
- Private Health Insurance Agencies
- College/University Plans
- Through a Parent’s Plan (if you are age 26 and under)

**WHY IS HEALTH INSURANCE IMPORTANT?**

Health insurance is important because it:

- Protects you from unexpected, high medical costs
- Allows you to pay less for certain health care services associated with your health insurance plan
- Gives you access to free care to prevent certain illnesses, like vaccines, screenings and check-ups

With certain health insurance plans, you don’t have to pay fees that many people who don’t have health insurance coverage must pay. Massachusetts also has an “individual health insurance mandate,” which requires most adults to have health insurance if it is affordable to them and meets certain coverage standards.

**WHAT IS PRIVATE HEALTH INSURANCE?**

Private health insurance is usually offered through your employer (where you work). Some employers offer only one type of health insurance plan, while others may let you choose from more than one.

Some people have to buy their own private health insurance, instead of getting it through an employer. This usually costs more since an employer doesn’t share the cost. Examples of private health insurance companies include Harvard Pilgrim Health Care, Blue Cross Blue Shield and Cigna.

**WHAT IS MANAGED CARE?**

Some private insurance plans work with certain health care providers that are part of the health plan’s network to provide care at lower costs. This is called managed care. There are different kinds of managed care plans:

- **HEALTH MAINTENANCE ORGANIZATIONS (HMOs):** With an HMO plan, you pick one primary care physician, called a PCP. All your health care services go through that doctor. That means that you need a referral before you can see any other health care professional (except in an emergency). Visits to health care professionals outside of your network typically aren’t covered by your insurance.

- **PREFERRED PROVIDER ORGANIZATIONS (PPOs):** PPO plans give you flexibility. You don’t need a primary care physician (PCP). You can go to any health care professional you want without a referral—inside or outside of your network. Staying inside your network means smaller copays and more coverage. If you choose to go outside your network, you’ll have higher out-of-pocket costs, and not all services may be covered.

- **POINT-OF-SERVICE PLAN (POS):** A point-of-service plan (POS) is a type of managed care plan that is a mix of an HMO and PPO plan. Like an HMO, you must choose a doctor in your insurance network to be your primary care physician (PCP). But like a PPO, you may go outside of your insurance network for health care services. If you go out of the network, you’ll have to pay most of the cost, unless your PCP has made a referral to the out-of-network provider. Then the medical plan may cover the cost.

**WHAT IS PUBLIC INSURANCE?**

You might qualify for government-supported programs like Medicaid or Medicare.

- **MEDICAID** is a government-run insurance program that helps some people with lower incomes pay for health care. Medicaid is available only to certain people who have low-to-medium income and are eligible. Learn more about Medicaid at [www.mycarema.org](http://www.mycarema.org).

- **MEDI-CARE** is a health insurance program run by the Social Security Administration that pays some insurance costs for people 65 and older and who have certain disabilities or health problems. Read about government-supported options on the government’s website: [healthcare.gov](http://healthcare.gov).

**MASSACHUSETTS OFFERS SEVERAL PUBLIC AND PRIVATE PLANS THROUGH MASSHEALTH AND COMMONWEALTH CARE.** These can be free or low cost. Take a look at the “What is MassHealth?” section below or visit [masshealthconnect.com](http://masshealthconnect.com) for more information.
WHAT ARE STUDENT HEALTH PROGRAMS?
Massachusetts college students are required by law to have health insurance, and colleges must offer health insurance to their students. These health plans are called Student Health Programs (SHPs). Students who enroll in a Massachusetts college must pay for the school’s SHP plan or prove that they have other health insurance that is at least as good (comparable coverage).

WHAT SHOULD I CONSIDER WHEN CHOOSING A HEALTH PLAN?

<table>
<thead>
<tr>
<th>Plan</th>
<th>Example</th>
<th>Option A</th>
<th>Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium (amount you pay to belong to a health plan; usually due on a monthly basis)</td>
<td>$58 x 12 months = $696</td>
<td></td>
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</tr>
<tr>
<td>Deductible (amount you pay out-of-pocket before insurance coverage kicks in)</td>
<td>$500</td>
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<tr>
<td>Primary Care Visits (usually a family practice doctor, internist, gynecologist, or pediatrician; this doctor is your first point of contact with the health care system)</td>
<td>$25 copayment/visit (2 visits/year)</td>
<td></td>
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<tr>
<td>Speciality Visits (this is a visit with a provider other than a primary care provider, or PCP; usually requires a referral from your PCP)</td>
<td>$35 copayment/visit (1 visit/month)</td>
<td></td>
<td></td>
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<tr>
<td>Emergency Room Visits (many insurance plans waive this fee if admitted inpatient)</td>
<td>$125 copayment/visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Admissions</td>
<td>$1200 copayment/inpatient stay</td>
<td></td>
<td></td>
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<tr>
<td>Physical Therapy/Occupational Therapy/Other Therapies</td>
<td>$35 copayment/visit</td>
<td></td>
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<tr>
<td>Prescriptions (medications are separated into different levels—or tiers—depending on their cost; if you are prescribed a tier 3 medication, ask your doctor if there is a less expensive equivalent)</td>
<td>$10 = tier 1 (2 meds/month)</td>
<td>$20 = tier 2</td>
<td>$30 = tier 3</td>
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<tr>
<td></td>
<td>Tier 1 = least expensive, generic</td>
<td>Tier 2 = mid-range</td>
<td>Tier 3 = most expensive</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (a yearly cap on out-of-pocket costs, excluding premiums)</td>
<td>$2500/year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Limit (a yearly cap on the dollar amount or types of benefits; once you’ve reached your cap, you must pay the full cost of the health care for the rest of that year)</td>
<td>$1.25 million</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Details (mental health coverage, vision coverage, maternity benefits, travel expenses for getting to appointments and inpatient stays, reimbursements for gym membership, weight loss programs, other programs, additional medical expenses)</td>
<td>$696 (premium) + $500 (deductible) + $50 (PCP visits) + $420 (specialty visits) + $840 (mental health visits) + $240 (prescriptions) = $2746</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HOW LONG CAN MY CHILD STAY ON MY HEALTH INSURANCE?
The law requires insurance companies to allow you to be able to keep your child on your current family health plans until she is 26 years old. If your child has a job, it’s a good idea to compare the costs and benefits of that plan with your current plan.

I HAVE A DISABLED CHILD. WHAT ARE MY OPTIONS?
If you have an adult disabled child who can’t gain employment due to a disability (intellectual and/or physical), she is allowed to stay on your private health insurance past the age of 26. You may need to fill out additional paperwork to keep your child on your plan.

DISABLED ADULT CHILDREN WHO ARE COVERED BY THEIR PARENT’S MASSHEALTH PLAN MUST SWITCH TO THEIR OWN MASSHEALTH PLAN AT AGE 19.

In order for you to continue to communicate with MassHealth about your child’s plan, your child must sign a “release of information” form after she turns 18. This is required even if you are the legal guardian. Also, MassHealth can serve as a secondary insurance or a primary insurance.

CONSIDER WHAT PRESCRIPTION DRUGS YOUR CHILD TAKES on a regular basis. Add up the copays and out-of-pocket costs to fill these prescriptions.

IN-NETWORK PROVIDERS: Doctors who have a contract with a health insurance plan, so you pay less out of pocket to see them.

OPEN ENROLLMENT: A set period, usually at the end of the year, when you can enroll in a group health plan or change from one plan to another. Outside of open enrollment, only certain life-changing events (marriage, birth, divorce, etc.) may permit you to join or change plans.

OUT-OF-POCKET LIMIT (continued): This limit the total amount of money you pay each calendar year for health care, including co-pays and deductibles. For example, if your policy carries a $1,000 out-of-pocket maximum and you get sick and require a lot of health care services, the most you will pay in a year is $1,000. After that, your insurance picks up the costs.

OUT-OF-NETWORK PROVIDERS: Doctors who do not have a contract with a health insurance plan, so you may be responsible for the entire bill.

REFERRAL: This is a written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don’t get a referral first, your plan may not pay for the services.