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Types of Health Insurance Plans

There are many types of health insurance plans:

- Managed Care Plans: health maintenance organizations (HMOs), point-of-service plans (POS), preferred provider plans (PPOs)
- [Fee-for-service plans](#)¹
- [Catastrophic coverage](#)²
- Health savings accounts
- Hospital indemnity policies
- Cancer insurance and other supplemental insurance

They all require you to pay a monthly fee, called a **premium**. Most of them also require you to pay either a flat fee for doctor's office visits and other services (called a **co-pay**), or a percentage of the cost (called **co-insurance**). Some services require you to pay both a co-pay and co-insurance. Each year, most people also have to pay a certain dollar amount of their medical costs, known as the **deductible**, before insurance will start to pay at all. After you have met your deductible, your insurance will pay a set percentage of your bills for medical care for the rest of the year. In addition, all insurance plans must set an **out-of-pocket maximum** that an individual or family are required to pay before the health insurance plan covers 100% of covered benefits.

Deductible: A dollar amount that you must pay each year for health services before the insurance plan covers anything.

Co-payments or **co-pays:** The amount you must pay at the time of service, usually a flat fee for office visits and other services. Sometimes confused with co-insurance, but they're not the same.

Co-insurance: A percentage of each medical bill you must pay even after you've paid the yearly deductible amount.

Out-of-pocket maximum: The most an individual or family has to pay for services covered by the insurance plan in a plan year.

If your doctor accepts your insurance, their office will often bill the insurance company for you, and then send you a bill for the amount your insurance didn't cover. If not, you might have to pay your medical bills yourself and then fill out forms and send them to your insurer to get paid back.

You must keep track of your own medical expenses and payments you and your insurance company make. These records can help you greatly if there's a dispute about payments or other problems in the future. Read more on [Keeping Copies of Important Medical Records](#)³.

The health plans are explained briefly here. Even though we will describe the types of health plans you can find in the private sector (work-based and individual insurance plans), many of the government sponsored plans use some of the same approaches and terms as private plans. You can learn more about [government-funded programs](#)⁴, such as Medicare, Medicaid, and CHIP.

It's important to know that some health insurance plans might not cover all your healthcare needs. Here are some helpful things to consider when selecting a plan:

- Verify if the plan is a [Qualified Health Plan](#)⁵
- Confirm that your doctors, specialists, and pharmacy are in the new network. If they are not, check your out-of-network costs.
- Confirm that your current medications are covered in pharmacy drug formulary.
- Review all covered health services as well as the plan's list of **excluded services and limitations**.

Each health insurance plan is different, but some commonly excluded services and limited coverage include: unproven or experimental cancer therapies, acupuncture, homeopathic or herbal drugs, long-term care, private duty nursing, non-prescription drugs, or services, equipment and products that may *not be medically necessary* for your healthcare.

Understanding out-of-pocket costs before service

Starting in 2022, health care facilities, health care providers, and health insurance companies will be required by law to give people information on costs before services are given. If a person is receiving care from an out-of-network facility or provider, health

care facility or provider will be required to give information about the potential out-of-network costs. People with health insurance can get this information from their health insurance providers, while people without health insurance can get an estimate from their health care providers or facilities before receiving services. This new law is intended to help protect consumers from surprise bills. To learn more, visit www.cms.gov/nosurprises⁷.

Health insurance scams are everywhere

Watch out for [health insurance scams](#)⁸ (ads or agents offering medical discount cards, or "government-issued," or stripped down, low-cost health insurance). There are also "insurance specialists" or "government agents" who call and ask for personal details, or credit and bank information. These con artists operate online, by phone, and door-to-door.

Managed care plans

These types of plans typically coordinate or manage the health care of enrollees. There are different types of managed health care plans. Some plans – like health maintenance organizations or HMOs – have a more limited network of providers and hospitals while other models like Preferred Provider Organizations (PPOs) have a wider provider network.

Many different types of institutions and agencies sponsor managed care plans, not just insurance companies. These include employers, hospitals, labor unions, consumer groups, the government, and others. It helps to know all the ins and outs of the plan and how it will affect your care. The most common types of managed care plans are:

- Health maintenance organizations
- Point-of-service plans
- Preferred provider plans.

Most managed care plans have lower premiums, co-pays, and/or co-insurance than traditional fee-for-service insurance. Premiums, co-pays, and co-insurance amounts can differ between managed care companies and even between services within the same company. There's usually no need to file claim forms.

Some managed care plans require members to use a primary care provider who coordinates all of the patient's care and serves as a "gatekeeper" for care from specialists. The gatekeeper is usually a primary care doctor who's responsible for the

overall medical care of the patient. This doctor organizes and approves medical treatments, tests, specialty referrals, and hospitalizations. For example, if you need to see an expert like a lung specialist, you would need a referral from your primary care doctor before the specialist sees you. Otherwise your plan might not pay.

Under most plans, members must use only the services of certain providers and institutions that have contracts with the plan. These plans may require that members choose providers from a particular list or network of providers. When you choose to go outside the network for care, you generally have to pay more, or even pay for the full service with no help from your health insurance plan. Some of these plans will pay at least part of the cost of seeing someone outside the network if you get approval from the plan before the visit or service (also called [pre-authorization](#)⁹).

Health maintenance organizations (HMOs)

The HMO will usually cover most expenses after your co-pay and you meet your deductible. HMOs often limit your choice of providers to those within their approved provider network. This means you have to check their listing to be sure the doctor you want to see is one of their doctors. If not, the bill may not be covered in full or at all.

Point-of-service plans (POS)

A point-of-service plan (POS) is a type of HMO. The primary care doctors in a POS plan usually refer you to other doctors in the plan or network. If your doctor refers you to a doctor who's not in the plan (out of network), you should check to see if the plan will pay all or part of the bill before you go. But if you choose a doctor outside the network, you will have to pay co-insurance, even if the service is covered by the plan.

Preferred provider organizations (PPO)

The preferred provider organization (PPO) is a hybrid of fee-for-service (below) and an HMO. Like an HMO, there are only a certain number of doctors and hospitals you can use to get the lowest cost-sharing. When you use those doctors (sometimes called **preferred** or **network** providers), most of your medical bills are covered. You pay more to choose providers that are not in the network.

Going out-of-network for health care

Sometimes you must go outside your network for care. It might cost more, but you may be able to reduce your costs if you discuss this with your health plan administrator – sometimes they will pay more if they agree it's needed. Find out what the insurer will

pay and how much you'll have to pay, or if you can get prior authorization from them to get out-of-network care.

You can also negotiate costs up front with doctors, clinics, and hospitals when surgery, procedures, or other treatments are planned. You can use information you were able to get from your plan to find out if the medical facility or clinic will be willing to accept the amount paid by insurance as full payment. If not, ask if they're willing to discount the portion you're asked to pay.

You can also appeal your plan's decision if they don't agree to cover the out-of-network care. See [If Your Health Insurance Claim Is Denied¹⁰](#).

Fee-for-service plans

Fee-for-service plans are the least restrictive plans that offer the most choice in medical providers. They are also called **traditional** health plans. If you have this type of health insurance, you can go to any doctor or hospital who accepts your particular health insurance plan and change doctors at any time.

Other types of health coverage

Some other kinds of insurance suggest that they pay for hospitalizations and major medical expenses, but these claims can be misleading because of what they don't tell you. You'll need to know more to make an informed decision.

Catastrophic coverage

Treating and managing most cancers costs a lot of money. Some insurance plans offer supplemental coverage called **catastrophic coverage**. **These plans do NOT cover routine medical expenses, but may only help cover worst-case health scenarios, such as having a serious illness or injury.** These often seem attractive because they have fairly low premiums. It's important to know these plans generally have high deductibles and routine medical expenses are the responsibility of the patient (unless you also have another type of coverage along with catastrophic coverage).

One example is a catastrophic illness insurance that is referred to as a **hospital-only plan**. **This plan usually won't cover doctor visits, medicines, or routine care, and start to pay only when you are hospitalized and have very high expenses.**

Depending on the policy, you can expect to pay a few thousand dollars for the deductible alone and some percentage of co-insurance on the rest of the bill, plus the

total cost of any items and services not covered by the plan.

Even though they are sometimes called hospital-only, the plans won't necessarily cover all or even most of your hospital bill. It's important to understand exactly what the plan will cover, and not rely on a catastrophic plan for your health coverage.

Catastrophic coverage plans may be offered in some [state health care Marketplaces](#)¹¹ to people with low incomes or who are exempt from having to get standard health coverage. People with this hardship exemption don't have to pay a penalty at tax time. But a person who requests an exemption from buying a regular health plan can't get help paying the premiums for catastrophic coverage, even if their income is very low. Still, Marketplace catastrophic plans have advantages over non-Marketplace ones. Catastrophic plans sold in the Marketplace must cover 3 annual doctor visits and preventive benefits.

If you have a catastrophic plan and get an expensive illness like cancer, you can end up paying a high deductible, and up to 40% of your hospital bills out of pocket. Most catastrophic plans have an out-of-pocket limit, but services the plan doesn't cover don't count toward that limit. For instance, catastrophic plans typically don't cover prescription drugs, which can be costly when you consider that some of the newer cancer treatment drugs cost more than \$100,000 per year.

Catastrophic plans may also end up costing more than the out-of-pocket limit if the person gets out-of-network care. If you choose to get such a plan, find out if prescription drugs are covered, ask about out-of-network costs, and if either of these expenses are included in the out-of-pocket limit.

Health Savings Accounts, Health Reimbursement Arrangements, and more

If you have enrolled, or plan to enroll, in a high-deductible health plan such as a catastrophic plan, you may be able to set up a Health Savings Account (HSA). You don't have to pay federal income taxes on the contributions you make to the HSA if the money is used to pay for qualified medical expenses. If you use it for anything else, you will be required to pay the tax and a penalty.

An HSA is different from a Flexible Spending Account (FSA). For instance, you can have an FSA even if you don't have a high-deductible health plan. FSA funds can be set up to be used for medical or dependent care expenses. You will need to use up the entire amount by the end of the year (use it or lose it). HSA money; however, is yours until you take it out. For more information about setting up an HSA contact your employer, bank, or credit union.

There is also an employer-based Health Reimbursement Arrangement, or HRA. It's a special benefit that pays for medical expenses that the health plan doesn't cover, such as deductibles and co-insurance. But the employer puts in the money and decides which expenses to pay. The employer also decides whether any leftover money in the HRA can be rolled over to the next year. And, you don't get to keep the money if you leave the company.

Hospital indemnity policies, cancer insurance, and other supplemental or health-related insurance

Hospital indemnity policies, sometimes called **supplemental medical policies**, pay a fixed amount for each day you are in the hospital. There may be a limit on the total number of days it will pay for in a calendar year, or a cap on the total number of days it will ever pay. The money you get from this type of policy can be used in any way the insured person wishes. It's often used for medical costs not paid by the health insurance plan, or the other expenses that families face when one member is ill.

These supplemental plans don't offer the kind of coverage needed for a disease such as cancer. So, if this is your only form of coverage, you'll also be paying large out-of-pocket costs if you have a serious illness.

Critical-illness and cancer insurance policies

There are other types of policies that offer extra money in case of certain kinds of health problems such as cancer, stroke, or an accident. They typically cover some part of the expenses that your regular health insurance doesn't, like deductibles and co-insurance. Others just give you a fixed amount of money if you are diagnosed. You can't buy these critical-illness policies after you are diagnosed, and there are often limitations and waiting periods. It's important to understand exactly what the plan will cover, and not rely on this type of policy for your health coverage. These policies DO NOT cover most of the healthcare services a patient needs.

Long-term care insurance

This is NOT a type of health insurance, but it helps cover long-term medical and non-medical care given to people who need help performing basics like eating, dressing, walking, toileting, or bathing. Unpaid family members often provide this kind of care in the home, but that option isn't available to everyone. Long-term services might be given by paid staff at home, or in community homes, assisted living homes, or nursing homes.

Long-term-care insurance policies vary. For instance, most policies don't start paying

until more than 90 days of such care are needed, but some wait up to a year to start covering it. Home health care may be covered separately or not at all in some policies. Long-term-care insurance can be very expensive. Medicare and most health insurance plans don't pay for long-term care. Some states cover long-term care under Medicaid for people who qualify for Medicaid and meet other state requirements where they live.

You can learn more about the types of health insurance plans on healthcare.gov¹².

Also see the Additional resources at the bottom of the page for organizations that can give you more information about your health insurance options.

Hyperlinks

1. <http://www.healthcare.gov/glossary/fee-for-service/>
2. <http://www.healthcare.gov/glossary/catastrophic-health-plan/>
3. www.cancer.org/treatment/survivorship-during-and-after-treatment/long-term-health-concerns/keeping-copies-of-important-medical-records.html
4. www.cancer.org/treatment/finding-and-paying-for-treatment/understanding-health-insurance/government-funded-programs.html
5. <http://www.healthcare.gov/glossary/qualified-health-plan/>
6. www.healthcare.gov/glossary/qualified-health-plan/
7. www.cms.gov/nosurprises
8. www.cancer.org/treatment/finding-and-paying-for-treatment/understanding-health-insurance/health-insurance-scams.html
9. www.cancer.org/treatment/finding-and-paying-for-treatment/managing-health-insurance/getting-medical-pre-approval-or-prior-authorization.html
10. www.cancer.org/treatment/finding-and-paying-for-treatment/managing-health-insurance/managing-health-insurance-when-someone-has-cancer.html
11. www.cancer.org/treatment/finding-and-paying-for-treatment/understanding-health-insurance/private-insurance-options.html
12. <http://www.healthcare.gov/fees/plans-that-count-as-coverage/>

Additional resources

Along with the American Cancer Society, other sources of information and support are listed below.

US Department of Health and Human Services, State Health Marketplaces & more

Toll-free number: 1-800-318-2596 (also in Spanish) TTY: 1-855-889-4325

Website: www.healthcare.gov

Provides information on the new insurance law, takes you through the steps of finding insurance, and much more. If you don't have Internet access, the phone number will help you connect with your state's Marketplace to sign up for a plan

You can learn about **hardship exemptions** (which allow some people to avoid the penalty for not having health insurance) at <https://www.healthcare.gov/fees-exemptions/exemptions-from-the-fee/#hardshipexemptions>

US Department of Health and Human Services

Medicaid Toll-free number: 1-877-696-6775 Website: www.medicaid.gov/index.html

Medicare Toll-free number: 1-800-633-4227 TTY: 1-877-486-2048

Website: www.medicare.gov

Your state social service or human service agency can give you the best answers to questions about your benefits, eligibility, and fraud.

Answers questions, provides literature, and gives referrals to state Medicare offices and local HMO's with Medicare contracts.

Department of Veterans Affairs Toll-free number: 1-800-827-1000

Website: www.va.gov

For information on Veteran's medical benefits and whether you qualify for them Toll-free number: 1-877-222-8387 Website: www.va.gov/healthbenefits/apply/veterans.asp

*Inclusion on these lists does not imply endorsement by the American Cancer Society.

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Department of Veterans Affairs (VA). Health care benefits. Accessed at

https://www.va.gov/opa/publications/benefits_book/Chapter_1_Health_Care_Benefits.asp on April 12, 2019.

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