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Types of insurance: A breakdown

Kimberly Hartmann (Firefly84) is living with autonomic neuropathy, a rare disease that forced an end to her career as a registered nurse. In her time as an RN, she was often charged with navigating the ins and outs of insurance companies on behalf of her patients. Here she shares some insights into the different types of insurance plans available.

Public insurance

Medicare

A federal health insurance program for people 65 and older and certain younger people with disabilities.

Kim's comments: Income is not considered with this federal insurance. If you are under 65, you are eligible if you have received at least 24 months of Social Security Disability benefits or a Railroad Disability Pension. You are also eligible if you have end-stage renal disease (permanent kidney failure) and require dialysis. ALS (Lou Gehrig's disease) is another condition that will make you eligible.

Medicaid

Insurance program that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities.

Kim's comments: Medicaid is both federally- and state-funded and is for lower income populations. You can be eligible for both Medicare and Medicaid under certain circumstances. Benefits and program names vary somewhat between states.

Healthcare.gov

The exchange is a government-regulated marketplace of insurance plans with different tiers, or levels of coverage, offered to individuals without healthcare or to small companies.

Kim's comments: If you happen to be in the Healthcare Exchange (healthcare.gov), you will notice that there are tiers of coverage listed that happen to be metal. Bronze, silver, gold and platinum are the categories. The reason these exist is so that you can compare apples to apples. A gold HMO plan from one company can be compared to a gold HMO plan from another company. Premiums, deductibles, and additional plan information are compared side by side. As the quality of the metal increases, so does the coverage and also the premiums that you pay. Here's a quick breakdown, note that these are estimates and your costs will vary.

Plan category	Insurance company pays	You pay
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

Private insurance

Exclusive Provider Organizations (EPO)

A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

Kim's comments: This type of insurance has a little freedom as far as choosing providers. You don't need a referral to see a specialist. There is no coverage for out-of-network visits, unless it is an emergency, otherwise you pay the entire bill! Yikes, that can hurt a lot. Premiums are generally lower than a PPO plan.

Health Maintenance Organization (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency.

Kim's comments: With this insurance policy, you are required to have a PCP (Primary Care Physician), who is your "go-to" person for pretty much everything. If you need to see a specialist, they have to put in a referral. There are also networks set up for whom you can and can't see. The biggest takeaway is STAY IN-NETWORK!

Point of Service (POS)

A type of plan where you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

Kim's comments: This plan also has more freedom for choosing providers. Your PCP coordinates care and refers you to specialists. You can go out-of-network, but you will pay more; also, you'll pay the entire amount yourself and then get reimbursed by insurance - keep this in mind!

Preferred Provider Organization (PPO)

A health plan that contracts with medical providers to create a network of participating providers. You pay less if you use in-network providers. You can use providers outside of the network for an additional cost.

Kim's comments: These plans do not require referrals to see a specialist. It's more expensive to go out-of-network than to stay in. Similar to the POS policies, if you see a provider outside of the network, you will pay the cost and then insurance may offer a reimbursement. As always, it's important to speak with your insurance company before you see an out-of-network provider so you know how much you can be reimbursed.