Quick Guide to Health Insurance

To find healthcare coverage that's appropriate for you, it helps to understand the basics:

Health Insurance Plans differ because of two payment systems:

1 **Fee-for-service:**
The insurer pays a doctor or other healthcare provider a fee for each service. With these plans, **you visit any available provider.** You pay a portion of the cost for your care, and the insurer pays the rest. $$$$

2 **Managed Care:**
Providers join a network set up by a health insurance company. In turn, the provider agrees to a certain payment rate for treating you (called the "allowed amount.") That allowed amount determines your final cost. You typically pay a portion of the allowed amount, depending on your plan.

Managed care plans typically come in three types:

Health Maintenance Organizations (HMOs)

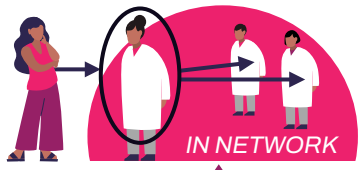
Healthcare starts with your primary-care physician, who usually must approve you seeing other providers, including specialists. HMO networks typically include fewer providers and will not pay for providers outside their network. Their smaller networks reduce choice — and expense. $

Exclusive Provider Organizations (EPOs)

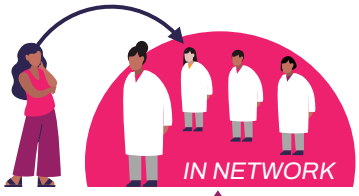
Sort of a hybrid of HMOs and PPOs in cost and flexibility. Usually, you need not start with your primary-care physician. Most EPOs also have larger provider networks than HMOs and are more costly, but like HMOs, will not pay for services obtained outside of the network. $$

Preferred Provider Organizations (PPOs)

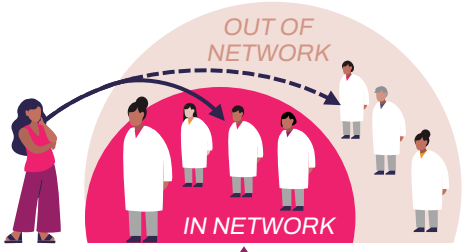
Generally, you need not start with your primary-care physician. Most PPOs offer out-of-network coverage for an extra charge, so staying inside your network leads to lower costs for you. Typically, PPOs cost more than HMOs and EPOs, but you get more choice and control. $$$



PRO: Less costly
CON: Less choice



PRO: More flexibility
CON: No out of network coverage



PRO: Most choice
CON: Most costly

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For more information, visit autoimmune.org

What questions should I ask when comparing health plans?

1. What will the plan actually cost me?
2. Are my healthcare providers and facilities in the plan's network?
3. Does the plan cover prescription drugs and pharmacies I use?

How do I calculate the real cost of a plan?

When comparing plans, look beyond the monthly premium because the total cost includes your out-of-pocket expenses. Do the math:

$XXX	Monthly premium x 12 months
+ **$X,XXX**	Out-of-pocket maximum
$X,XXX	Potential total annual cost

Example: Plan A below is a tempting choice because it has a lower monthly premium, so appears cheaper:

	Plan A HMO	Plan B PPO
Monthly premium:	**$25**	**$100**
Annual deductible:	$2,500	$1,500
Coinsurance:	70/30	80/20
Out-of-pocket max:	$7,000	$4,000

After doing the math, **Plan B** is actually more affordable if you think you may reach the out-of-pocket maximum due to treatments for your autoimmune condition.

	Plan A: $25/mo.	Plan B: $100/mo.
12 months of premiums:	$300	$1,200
Out-of-pocket maximum:	+ $7,000	+ $4,000
Total annual cost:	**$7,300**	**$5,200**

LIFE STORY: Out-of-pocket maximums

Marta went to the emergency room due to an autoimmune reaction and then spent a week in the hospital that was in her plan's network.

Marta's Insurance plan:
- ER co-pay: **$250**
- Deductible: **$2,000**
- **80/20** co-insurance
- Out-of-pocket max: **$4,000**

	Hospital bill: **$102,000**
	Marta:
At the ER she pays her **co-pay:**	**- $250**
Later, she pays the rest of her $2,000 **deductible:**	**- $1,750**
Usually, her **coinsurance** would be 20% ($20,000) of the remaining $100,000 bill. But her **$4,000 out-of-pocket max** means she only owes $2,000 after meeting the deductible:	**$100,000** ~~$20,000~~ **- $2,000**
Marta's total out-of-pocket cost	**- $4,000**

What if my insurance plan says no to a treatment?

An insurer may deny coverage, perhaps for a scan, medication, biologic, procedure, or genetic test. Most people take "no" for an answer. But if you appeal, you may get coverage for the care prescribed by your healthcare team!

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What questions should I ask about my prescription drug coverage?

Does my policy have separate prescription deductibles and maximums?

Some insurance policies have **separate deductibles and out-of-pocket maximums** for prescription drugs. If so, your insurance company calculates medical expenses toward their deductible, and prescription drug costs separately toward their deductible, before the policy pays its share for either.

LIFE STORY: Prescription drug cost maximum

Jordan takes a biologic for Crohn's disease. He has a separate deductible and out-of-pocket maximum for prescriptions.

Jordan's insurance plan:

- Rx co-pay: **$50**
- Rx deductible: **$1,000**
- **70/30** co-insurance
- Out-of-pocket maximum: **$1,500**

	Rx cost: **$10,000**
	Jordan:
Jordan's prescription **co-pay:**	**- $50**
Later, he pays the rest of the $1,000 **deductible:**	**- $950**
Usually, his **coinsurance** would be 30%($2,700) of the remaining $9,000 bill. But his **$1,500 out-of-pocket max** means he only owes $500 after meeting the deductible:	**$9,000** ~~$2,700~~ **- $500**
Jordan's total out-of-pocket cost	**- $1,500**

What are my pharmacy choices?

- **Retail pharmacies:** Usually, a physical location to pick up your prescriptions.
- **Mail-order pharmacies:** Some pharmacies also provide mail-order options. Some health plans require mail-order prescriptions if you will be taking it for more than 2-3 months.
- **Specialty pharmacies:** a pharmacy that provides specialty drugs.

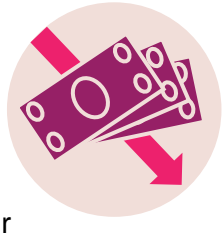
What if my medicine is not on the Formulary (list of covered prescription drugs)?

Generally, if a drug doesn't appear on the formulary, the insurance company will not pay for it. However, you may be able to file an **"exception request"** based on medical necessity for:

- **Non-formulary drug:** Covering a non-formulary drug.
- **Tier:** Treating a drug as if it were in a lower tier, reducing your out-of-pocket costs.
- **Brand:** Covering a higher-cost brand-name drug even if a generic is available

Generally, a request must be decided in 48 hours for nonurgent cases and 24 hours for urgent ones.

How can I lower my drug costs?



- Some plans require that you get your drugs from an **in-network pharmacy**.
- Some charge less if you use a **mail-order pharmacy**.
- Some states **limit out-of-pocket costs** for specific types of drugs.
- Some states have a **Pharmaceutical Assistance Program** (SPAP) (check medicare.gov)
- **Seek help that pharmaceutical companies provide.** They may help you understand your coverage. Many also offer financial aid such as co-pay assistance or free medication for eligible patients.

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Glossary of terms

HEALTH INSURANCE TERMS

Annual deductible: the amount you must pay each year before your policy kicks in. This fixed-dollar amount could be $500 or $5,000 or more. Some plans have a $0 deductible.

Co-insurance (aka cost-share): a percentage that determines what the insurance company pays for your medical expenses and what you pay. For example, if you have an 80/20 plan, the insurer pays 80% of your medical expenses and you are responsible for 20%, after paying your deductible.

Co-payment: a fixed-dollar charge when getting medical care. For example, visiting the doctor's office might include a $20 co-payment; seeing a specialist often comes with a higher co-payment, perhaps $40. You usually make your co-payment when you get care.

Monthly premium: what you pay each month to have coverage – you pay these costs even if you don't get medical care. It's like paying for car insurance all year whether or not you file a claim.

Out-of-pocket maximum: a fixed dollar amount that is the maximum you'll pay for a year's medical expenses. It varies by plan and is a key item to understand. Generally, you reach your out-of-pocket maximum by paying your deductible, co-payments and co-insurance payments. It's everything you pay except your monthly premiums. If you reach your out-of-pocket maximum, your insurance pays 100% of medical expenses for the rest of the year.

PRESCRIPTION DRUG TERMS

Brand-name drugs: a prescription drug with a specific name and manufacturer. After a patent expires, other companies may sell a generic version.

Formulary: a list of prescription drugs included in a health plan and at what cost. Understanding a plan's formulary helps save money on medications. Some plans have formularies with multiple cost levels, known as tiers, which determine co- payment and co- insurance amounts for a prescription drug. A drug on a higher tier comes with higher out-of-pocket costs. For example, a tier 1 drug may have a $10 co-payment, while a tier 5 specialty drug may have a 30% co-insurance.

Generic drugs: a prescription drug with the same chemical makeup that is typically less expensive than a brand-name drug.

Specialty drugs: prescription drugs with high cost, complexity, or special handling. They include many drugs for cancer.

Step therapy: an insurance company requires patients to try a generic or lower-cost drug before getting a more expensive drug. If the lower-cost drug doesn't work, the insurer allows the patient to "step up" to another medicine. If your insurance company uses step therapy, your health care team might need to show the insurer that taking a specific drug is medically necessary.

Other resources on how to pick a plan:

- State trackers: https://nashp.org/state-trackers/
- Health policy updates: https://www.ncsl.org/health/ncsl-prescription-drug-policy-resource-centerto

Plan comparison worksheet

	OPTION 1	OPTION 2
Origin of plan	☐ Employer ☐ Marketplace ☐ Other	☐ Employer ☐ Marketplace ☐ Other
Plan type	☐ HMO ☐ PPO ☐ EPO/Other	☐ HMO ☐ PPO ☐ EPO/Other
Insurance company:		
Plan name:		
Is my primary care physician in network?	☐ Yes ☐ No	☐ Yes ☐ No
Are my hospitals and specialists in network?	☐ Yes ☐ No	☐ Yes ☐ No
Are the prescription drugs I take covered by the plan?	☐ Yes ☐ No ☐ Some	☐ Yes ☐ No ☐ Some
Monthly Premium	A	A
Deductible	B	B
Out-of-pocket maximum for an individual or family	C	C
Separate deductible for prescription drugs, if any	D	D
Separate out-of-pocket max for prescription drugs, if any	E	E
Co-Insurance (Cost-share)	%	%
If plan has out-of-network coverage, enter percentage	%	%

TOTAL OUT-OF-POCKET COSTS:

1 Does your plan have a separate deductible and/or out-of-pocket maximum for prescription drugs? If yes, use this formula.

OPTION 1	OPTION 2
(A x 12) + B + C + D + E =	(A x 12) + B + C + D + E =

2 Does your plan include deductibles in the out-of-pocket maximum? If no, use this formula.

OPTION 1	OPTION 2
(A x 12) + B + C =	(A x 12) + B + C =

3 Does your plan include deductibles and prescription out-of-pocket costs in the out-of-pocket maximum? If yes, use this formula. (Note: Plans sold on the State Health Insurance Marketplaces will always use this formula)

OPTION 1	OPTION 2
(A x 12) + C =	(A x 12) + C =

Disclaimer: This worksheet is a tool to provide general guidance may not apply to all cases. It should not be used as a substitute for professional services.