Insurance 101

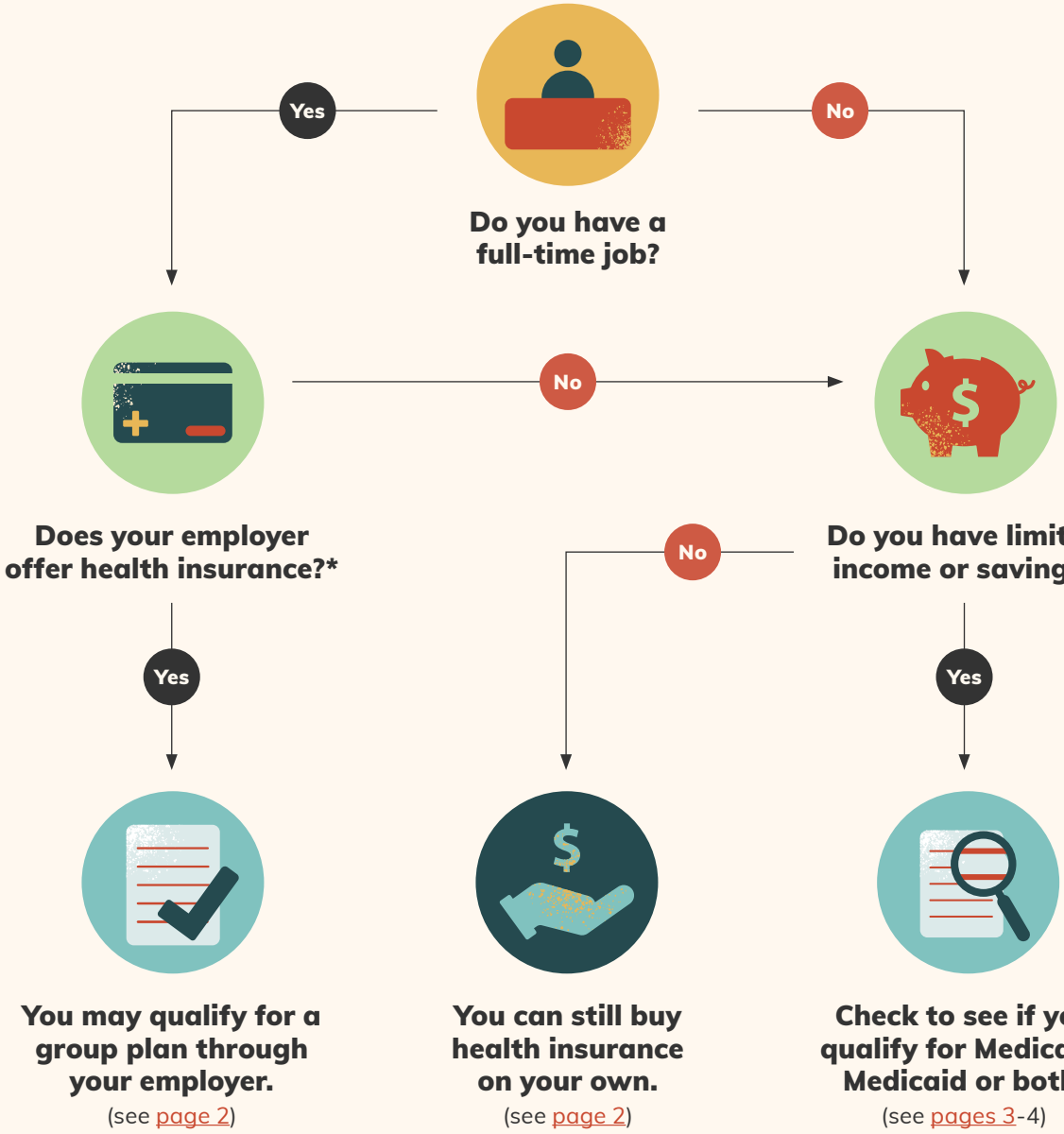
A guide to navigating plans and coverage options

Health insurance can be complex—we get it. But it's important to learn about the options available so that you can make a decision that's right for you.

Note: Eligibility for insurance plans is varied. You may not be eligible for every insurance plan mentioned in this guide.

Types of Health Insurance

There are 2 types of health insurance: **commercial** and **government funded**. Use these questions to see which type might be right for you. You can learn more about each type on the following pages.



*Keep in mind that you may be eligible to receive commercial insurance through the employer of your spouse or domestic partner.

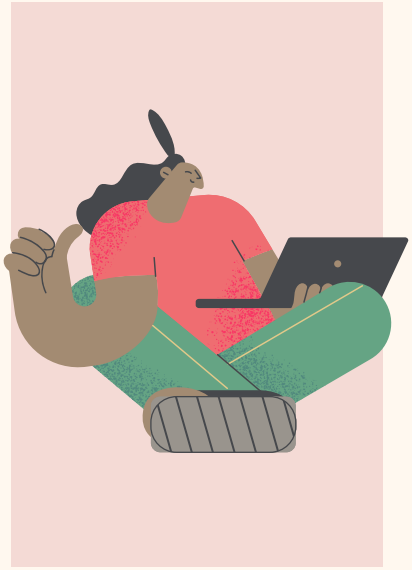
Commercial Insurance

When it comes to commercial insurance, there are 2 types of plans: **group plans** and **individual plans**.

Group Plans

A group plan is coverage provided by an employer or union. You may be familiar with some commercial health insurance companies. Some examples are Aetna, Blue Cross Blue Shield, and UnitedHealthcare.

Remember: If you are 26 years old or younger, it may be possible to be included on a group policy from your parent or guardian's employer.



Individual Plans

With individual plans, you purchase coverage directly from a private insurer or through the Health Insurance Marketplace (sometimes called the Health Insurance Exchange). The Marketplace, created as part of the Affordable Care Act, provides coverage to people who don't have access to a group-based plan, and who don't qualify for Medicare or Medicaid.

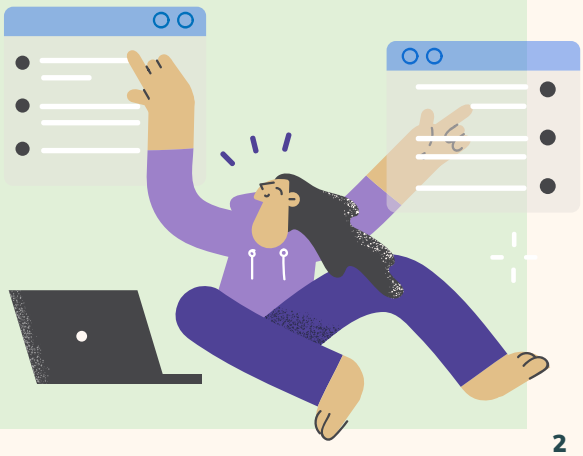
For more information about Marketplace plans, visit **www.HealthCare.gov**.

Before you purchase an individual plan, check to see if you qualify for **Medicaid** or **Medicare**.

Choosing a new insurance plan? Here's what you need to consider.

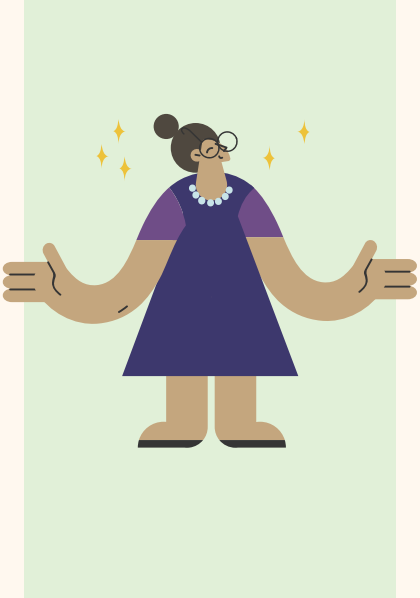
You may want to call each insurance company to find out:

- Does the plan cover your preferred doctors, specialists, pharmacies, and emergency care and hospital admissions?
- Are your prescriptions covered by the plan? (eg, on formulary or not, requires co-payment, goes toward the deductible)
- Does the plan cover generic and brand drugs?
- Are any prior authorizations required?
- What are the out-of-pocket costs, deductibles, and premiums?
- Research the ways you can reach a representative from a company to determine how easy they will be to contact



Government-Funded Insurance

People who qualify for government-funded health insurance have some or all of their healthcare costs paid for by the government. **Medicare** and **Medicaid** are 2 types of government-funded insurance.



Medicare

Medicare is the federal health insurance program for people who are 65 years or older, certain younger people with disabilities, and people with end-stage renal disease.

If you are eligible, Medicare offers different types of coverage for specific services:

- **Part A: Hospital Insurance Coverage**—covers services such as hospital stays and home healthcare
- **Part B: Medical Insurance Coverage**—covers doctor visits, lab tests, X-rays, medical equipment, and emergency department (ED) visits
- **Part C: Medicare Advantage**—combines all benefits and services listed under Parts A and B, and usually Part D
- **Part D: Prescription Drug Plan** (also known as the Medicare Prescription Drug Plan or PDP)—helps cover prescription medicine costs, including shots and vaccines

When you first sign up for Medicare, and during certain times of the year, you can choose which way to get your coverage:

Original Medicare

Original Medicare includes Part A (Hospital Insurance) and Part B (Medical Insurance). With both of these plans, you can usually use any doctor or hospital that takes Medicare, anywhere in the US.

These plans do not cover prescription drugs, so if you choose Original Medicare, joining a Part D (Prescription Drug Coverage) plan is important. Medicare Prescription Drug Coverage helps pay for prescription drugs you need. Each Part D plan can vary in cost an d specific drugs covered. The list of drugs covered is called a "**formulary**." Each plan has its own formulary where drugs are placed into different levels called "tiers." It is important to find out which plans cover the prescription drugs you take. You can also buy supplemental coverage from a private company to help pay for certain costs that are not covered by Medicare Parts A and B. One example is Medigap, which can help pay for your **out-of-pocket costs**.

Medicare Advantage (also known as Part C)

Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D. Each Medicare Advantage Plan can charge different out-of-pocket costs, can have different rules for how you get services, and can provide different benefits that Original Medicare doesn't cover—like vision, hearing, and dental services. In most cases, you'll need to use doctors who are in the plan's network.

Medicare Extra Help

Medicare Extra Help is a program that helps people who are on Medicare (who have Part D and qualify) with paying for their monthly **premiums**, **annual deductibles**, and **co-payments** related to Medicare prescription drug coverage.

If you have questions about your Medicare options, visit **www.Medicare.gov/talk-to-someone**. You can also visit the State Health Insurance Assistance Program (SHIP) website at **www.shiphelp.org** to find local Medicare assistance near you.

Medicaid

Medicaid is a joint federal and state program that helps with medical costs for some low-income adults, children, pregnant women, elderly people, and people with disabilities. It covers:

- Free or low-cost healthcare for low-income individuals who qualify
- Inpatient and outpatient hospital services, doctor visits, nursing home and home health services, and lab and X-ray services
- Prescription drugs

Be sure to check your state's eligibility guidelines for Medicaid before buying an individual plan. Keep in mind that some states may place limits on medicines.

Dual Eligibility

People who are dual-eligible are enrolled in both Medicare and Medicaid at the same time. Dual eligibility allows for more comprehensive coverage and typically applies to those with significant medical needs.

Medicaid does not pay for services covered under Medicare. Medicaid coverage only goes into effect after Medicare, employer plans, or Medigap plans have been applied.

Remember that there may still be out-of-pocket costs for those on government-funded insurance plans like Medicare and Medicaid. Also, starting or renewing coverage of any kind can affect out-of-pocket costs. Keep in mind that some plans have limits on out-of-pocket expenses.

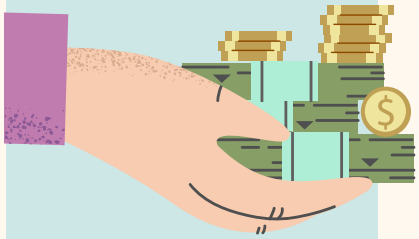
Things to Consider When Choosing an Insurance Plan

Research Coverage

Each plan has different health and prescription drug benefits and restrictions, so it's important to do your research to ensure your health needs are covered.

It's a good idea to call each insurance plan to confirm the following:

- Are preferred doctors, specialists, emergency care, and hospital admissions covered?
- Are your prescriptions covered?
- Does the plan cover generic, brand, and specialty drugs?
- Are **prior authorizations** needed?



Look at Out-of-Pocket Expenses

Deductibles, premiums, and other expenses can impact your overall healthcare costs.

Here are some steps you can take to better understand what your out-of-pocket costs may look like:

- Check if starting or renewing coverage will impact out-of-pocket costs. (For example, will prescription drugs cost more at the beginning of the year until your **out-of-pocket** limit is met?)
- Find out what the annual limit is on out-of-pocket expenses
- If your out-of-pocket expenses are met, will the plan cover 100% of expenses?
- Are the medicines you take to manage your cystic fibrosis (CF) classified as essential health benefits?
- How is manufacturer **co-pay assistance** applied towards your deductible and out-of-pocket limit?

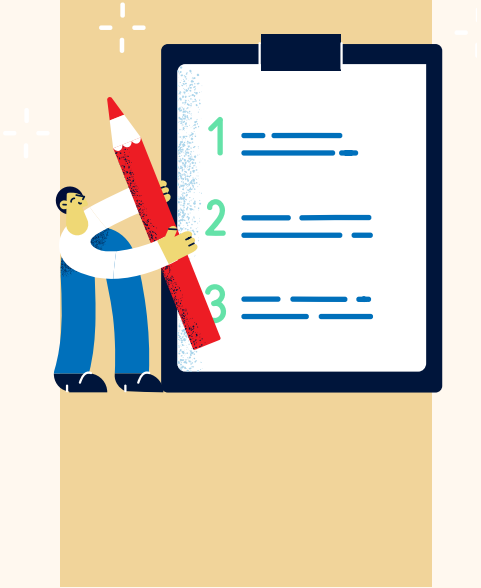
Use the worksheet on page 7 to help estimate what your out-of-pocket costs may be for the year to avoid surprises.

Under the Affordable Care Act (ACA), most commercial insurance plans have a limit on out-of-pocket costs that patients pay for "essential health benefits." When comparing insurance plans and calculating potential costs, find out about a plan's maximum out-of-pocket costs and what they classify as essential health benefits. The ACA limit on out-of-pocket costs can be found on HealthCare.gov.

Understand Co-Pay Adjustment Programs

Accumulators and maximizers are examples of **co-pay adjustment programs** that can prevent third-party co-pay assistance, including assistance from manufacturers, from counting towards your deductible, out-of-pocket costs, and/or your **out-of-pocket maximum**. Co-pay adjustment programs can result in changes to your out-of-pocket expenses.

If you rely on manufacturer co-pay assistance programs, it is important to understand whether your insurance plan uses one of these co-pay adjustment programs and assess how you may be affected. These programs can have names like *Accumulator Adjustment Program, Variable Co-pay Program, Coupon Adjustment: Benefit Protection Program, or Out-of-Pocket Protection Program*, and are not always easy to identify.



Here Are Some Tips for Identifying These Programs:

- Review the **Explanation of Benefits (EOB)** section of the insurance plan. This will outline how your deductible and out-of-pocket maximum are met
- Search the insurance plan's Schedule of Benefits or Pharmacy **Limitations** and **Exclusions** for keywords, such as coupon, co-pay card, manufacturer, and discount, to determine if there are any written restrictions for the co-pay assistance you may receive from manufacturer co-pay assistance programs
- Call your health plan and ask them directly how manufacturer co-pay assistance is applied or accepted

It can help to make a connection with a particular person within your insurance company and have their name and direct phone number on hand. Having a relationship with a real person can help you get your questions answered and may help you to resolve issues more quickly.

Making Changes to Your Health Plan

Here are some questions you can ask a representative to help you find out how your current plan (or options you are considering) could change your out-of-pocket costs:

- ☐ How is my current list of medicines covered? (Make sure they have a complete and up-to-date list)
- ☐ Are my medicines on a formulary?
- ☐ Do my medicines require a co-pay or co-insurance?
- ☐ Does the cost of medicines count towards my deductible?
- ☐ Does manufacturer co-pay assistance count towards my deductible and/or out-of-pocket maximum?
- ☐ If my representative confirms that I am in a co-pay adjustment program, how does this impact my out-of-pocket costs?
- ☐ What plan options are available to me?

Insurance Evaluation Worksheet

This worksheet can help you evaluate health plans and some of their benefits. Be sure to factor in any other costs you may have. If you need assistance completing this worksheet or have any questions about a plan you are considering, please reach out to the health plan provider. Also, refer to the Glossary on the following pages for the definitions of common insurance terms.

Insurance Plan A: _____ **Insurance Plan B:** _____

PLAN INFORMATION	PLAN A ($ PER MONTH)		PLAN B ($ PER MONTH)	
Premium • Individual				
Premium • Family or Individual +1				
Annual Cost	In-Network ($ Per Year)	Out-of-Network ($ Per Year)	In-Network ($ Per Year)	Out-of-Network ($ Per Year)
Deductible • Individual				
Deductible • Family or Individual +1				
Out-of-pocket Maximum • Individual				
Out-of-pocket Maximum • Family or Individual +1				
Amount of co-pay assistance you receive				
Does co-pay assistance count towards deductible and/or out-of-pocket maximum? (Write down Yes or No)				

MY CURRENT HEALTHCARE PROVIDERS		PLAN A		PLAN B	
Healthcare Provider	Name of Doctor	Covered (Y/N)	Co-pay/Co-insurance ($ or % per visit)	Covered (Y/N)	Co-pay/Co-insurance ($ or % per visit)
Primary Care					
Pulmonologist					

	PRESCRIPTION DRUG PLAN A			PRESCRIPTION DRUG PLAN B		
My Prescription Drugs	Covered (Y/N)	Co-pay/Co-insurance ($ or % per refill)	PA* Required (Y/N)	Covered (Y/N)	Co-pay/Co-insurance ($ or % per refill)	PA Required (Y/N)

*__Prior authorization__ (see Glossary)

Updating Your Insurance Policy

Here's what to do after you change your plan:

Get to Know Your Insurance Card

You will need to provide your new information to your care team. They may ask for your:

- **Member ID number:** This number is unique to you. It identifies you as an individual who is covered and allows you to access your benefits when you need care
- **Group number:** If you received insurance through an employer, a group number will also be listed on your card. This helps identify the benefits you receive through your employer's plan. Your care team may use this number to file claims

Tell Your Healthcare Provider

Once you've changed insurance policies, let your cystic fibrosis (CF) care center and other members of your healthcare team know about your switch.

Coordinate With Your Specialty Pharmacy

Make sure they are aware of your new insurance plan and any coverage changes as soon as possible.

Coverage Loss Related to Unemployment

If you lose your employer-based coverage, you may have the following options:

Special Enrollment Period

During this time, you can enroll in an individual plan by purchasing it directly from the Health Insurance Marketplace. You usually have 60 days from the day you lose coverage to enroll.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

With COBRA, you have the option to continue the coverage you received from your former employer for a limited period of time.

Medicare or Medicaid

If you qualify for government-funded insurance, you can enroll in these programs at any time.

Glossary of Insurance Terms

Here are some terms you may have seen in this guide or during your own research into healthcare coverage.

CLAIM
This is a request for payment that you or your healthcare provider submits to your health insurance company after you receive a medical bill. The specific care or services you received must be covered under your plan in order for you to be reimbursed.

COBRA
The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives individuals and families the right to continue receiving health insurance coverage after a loss of group plan benefits. This can be due to losing or leaving your job, a change in how many hours you work, death, divorce, and other life events. If you qualify, you may be required to pay the entire premium for coverage up to 102% of the cost to the plan.

COORDINATION OF BENEFITS
Sometimes 2 insurance plans work together to pay claims for the same person. That process is called coordination of benefits. Insurance companies coordinate benefits to avoid duplicate payments, to establish which plan is primary and which plan is secondary, and to help reduce the cost of insurance premiums.

CO-INSURANCE
The percentage of covered medical expenses you pay after you've met your deductible. Your health insurance plan pays the rest.

CO-PAY
A set amount you pay (the patient responsibility), for your prescriptions, doctor visits, and other types of care. Typically, a co-pay is a flat dollar amount.

CO-PAY ACCUMULATOR
A type of co-pay adjustment program that does not count co-pay assistance toward your deductible, out-of-pocket costs, and/or out-of-pocket maximum. Typically, manufacturer co-pay assistance funds prescriptions until the maximum value of the assistance is reached. After that, the patient's out-of-pocket costs begin counting toward their annual deductible and out-of-pocket maximum.

CO-PAY ADJUSTMENT PROGRAMS
Programs that do not count co-pay assistance towards your deductible, out-of-pocket costs, and/or out-of-pocket maximum. This co-pay assistance includes co-pay cards and traditional coupons provided by manufacturers.

CO-PAY ASSISTANCE
This is money that a drug manufacturer may provide to patients to help with the co-pay costs of a prescription. For example, many manufacturers offer this assistance in the form of co-pay cards or coupons.

CO-PAY MAXIMIZER
A type of co-pay adjustment program that does not count co-pay assistance towards your deductible and/or out-of-pocket maximum. Typically, the maximum value of the manufacturer's coupon/card is applied evenly throughout the benefit year.

DEDUCTIBLE
The amount you may have to pay for care or prescriptions before your insurance plan begins to pay.

HOW DOES IT WORK?
For example, you see an out-of-network specialist twice a month for $100 a session. Your out-of-network deductible is $1000. You will pay $100 for the first 10 sessions—until you reach $1000. After you meet the $1000 deductible, your specialist visits will be covered by your plan for the remaining calendar year. ***Note: You may still be responsible for a co-pay after your deductible is met.***

DRUG FORMULARY
The list of all prescription medications that your plan covers.

EXCLUSION OR LIMITATION
This refers to a specific drug, surgery type, act, or condition that your health insurance policy will not cover.

EXCLUSIVE PROVIDER ORGANIZATION
Type of plan that covers services only when you use doctors, specialists, or hospitals within the plan's network. Note: You must confirm your cystic fibrosis (CF) care center is in network before enrolling in an EPO plan.

EXPLANATION OF BENEFITS
A report or statement you receive from your insurance company that explains how they paid your claim, according to the benefits described in your health plan.

FORMULARY
A formulary is a list of drugs covered by an insurance plan. There are various types:

- Open: little or no limitation on the medications covered
- Restricted: some flexibility in choice of medication
- Closed: coverage limited to only the medications specified in the formulary

FULLY INSURED PLAN
A plan in which the employer pays a certain amount each month (the premium) to the health insurance company. In return, the insurance company covers the costs of the employees' healthcare.

HEALTH INSURANCE NETWORK
This refers to the entire network of healthcare providers, suppliers, and facilities that your health insurance plan works with

HEALTH MAINTENANCE ORGANIZATION (HMO)
This type of healthcare plan limits coverage to healthcare providers contracted within the HMO network only. You will select a primary care physician (PCP), who must then give you a referral whenever you need to see any in-network specialists.

IN-NETWORK CO-PAY/CO-INSURANCE
A fixed amount or percentage you pay for covered healthcare services to providers who are part of your health insurance plan's network. In-network co-pays/co-insurance usually cost less than out-of-network co-pays/co-insurance.

HOW DOES IT WORK?
Let's say your doctor bills you $100, and your health plan's co-pay or co-insurance amount is 20%. You would pay 20% of the total bill ($20), and your health insurance plan would pay the remaining 80% ($80) once any deductible is met.

IN-NETWORK PROVIDER
A healthcare provider who is contracted with the health insurance plan to provide care to policyholders for an agreed rate.

MANAGED CARE
A healthcare plan or system that seeks to control the quality and cost of medical services by contracting with a network of providers.

OPEN ENROLLMENT
Open enrollment is the annual period when you can sign up through your employer for a new health insurance plan, enroll in other benefit programs (such as a flexible spending account), or make changes to your existing plan.

OUT-OF-NETWORK CO-PAY/CO-INSURANCE
A fixed amount/percentage you pay for covered healthcare services to providers who do not contract with your health insurance plan. Out-of-network co-pay/co-insurance usually costs more than in-network co-pay/co-insurance.

OUT-OF-NETWORK PROVIDER
A healthcare provider who is not under contract with your health insurance plan. When you get care from an out-of-network provider, your insurance company typically pays either less or nothing at all for the services you received.

OUT-OF-POCKET COSTS
Costs that you have to pay on your own because they're not covered by your insurance plan. For example, if you elect to have a procedure that costs $1,000 and it's not covered by your plan, you will need to pay $1,000 yourself.

OUT-OF-POCKET LIMIT OR MAXIMUM
The most you pay during a policy period (usually per year) before your health insurance or plan pays for the full cost of covered benefits. Each plan is different; it's best to ask your insurance company what counts towards your out-of-pocket maximum.

PHARMACY BENEFITS MANAGER (PBM)
A third party who works on behalf of a health plan to help manage prescription drug benefits and process prescription-related claims. They have many different responsibilities, including coordinating with insurance companies, drug manufacturers, pharmacies, and insurance policyholders.

PREFERRED PROVIDER ORGANIZATION (PPO)
A type of healthcare plan that allows you to use providers both inside and outside of your network and get coverage for both. You will pay less for care from in-network providers.

PREMIUM
The monthly amount that must be paid for your health insurance or plan to keep your coverage active.

PRIOR AUTHORIZATION (PA)
You may need a prior authorization, or PA, before you can receive your medicine. If required, your healthcare provider works with your pharmacy to provide this information. A PA may need to be renewed after a certain amount of time. So, it may help to keep an updated list of your medicines that require a PA so you know when renewals are needed.

REIMBURSEMENT
The process through which the insurance provider pays healthcare providers for their services.

RETAIL PHARMACY
An independent, chain, supermarket, or mass-merchandiser pharmacy that is licensed to dispense medicines to the general public at retail prices.

SELF-INSURED PLAN
A type of insurance plan usually offered by larger companies where the employer collects premiums from people enrolled in the plan and manages payments.

SPECIAL ENROLLMENT PERIOD
The time outside the yearly open enrollment period when you can still sign up for health insurance. You qualify for a special enrollment period if you've had certain life events or unusual circumstances, like having a baby, getting married, or losing your current insurance. You usually have up to 60 days following the event to enroll in a plan.

SPECIALTY PHARMACY
A specialty pharmacy fills prescriptions for certain drugs that are not available at retail pharmacies. Vertex medicines are only distributed through specialty pharmacies.

SUMMARY OF BENEFITS AND COVERAGE (SBC)
This is the section in your insurance policy that details your benefits and how they are calculated, including deductible, co-payment, coinsurance amounts, and out-of-pocket limits.