National Kidney Foundation™

Council of Nephrology Social Workers

Insurance Toolkit

(July 2014)

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What Dialysis Patients Should Know About Transplant

Lara Tushla, MSW, LCSW, NSW-C

There are many physical, emotional, and support system differences between being on dialysis and having a kidney transplant, but this will focus on the financial aspects. I have learned these "the hard way," both from my transition from working in a dialysis unit to a transplant center and from the times when my recipients have been surprised… even if they were told.

THE AMERICAN KIDNEY FUND (AKF)

The Health Insurance Premium Program (HIPP), which assists in paying insurance premiums, is only available to patients who are on dialysis. The program specifically does not allow transplant centers to participate. Therefore, the insurance premiums will be the patient's responsibility after transplant. Often, having this insurance was an important part of the patient's being approved for transplant, financially, because it pays some important part of their post-transplant care. Most commonly this insurance is paying the 20% copays after Medicare on the immunosuppressant drugs which would run $250-500/month, depending on dosing.

- ❖ Patients need to know how much the premium for this insurance is and have a plan to be able to cover it after transplant or be responsible for the 20% copays, including those for the immunosuppressant drugs.

The Safety Net program is only available to patients who are within their first 5 years post-transplant. Applications need to be resubmitted yearly by a social worker; however, patients need to understand this is not done automatically. Patients will need to alert the social worker that it's time to reapply for the grant and request that the application be resubmitted.

MEDICARE

- Medicare Part B covers the anti-rejection medications, not Part D. The pro side of this is that these medications don't put patients into the donut hole. The con side is that if a patient qualifies for Extra Help but not Medicaid, the copay for the anti-rejection medications is several hundred dollars a month.
    - ❖ There are federal regulations that guide which insurance pays and in what order. Patients cannot decide that they want Part D to cover their immunosuppressant drugs because the benefits are better. They cannot decide that they want their employer plan to pay for their meds and other care primary forever.
- Patients have to keep Medicare Part B active! My center will put a person "on hold" with transplant if their Medicare is primary and the Part B is not active. Secondary payers have every right, and almost always will, to *only* cover the 20% copays that they would be responsible for.
- Many of the non-immunosuppressant drugs are incredibly expensive, so patients end up in the donut hole soon anyway. One anti-viral medication is $1200 per month, so it is common for the Part D copay to be $400/month.

- Even if the patient qualifies for Extra Help, there are still copays on the medications, albeit very limited.
- If the only reason a patient has Medicare is due to their ESRD, Medicare will end 3 years after the kidney transplant.
- Encourage patients to talk to the transplant team before signing up for a Medicare Advantage plan.
    - ❖ Often, patients end up with 20% copays on their immunosuppressant drugs and will have to transfer away from the transplant center because of contracting issues.

MEDICAID

- Spend down is very hard to meet after transplant. The only place after transplant where there is a consistent source of big medical bills to use toward spenddown, is the pharmacy… and they aren't going to give the patient the meds until payment is made. Pharmacies aren't going to write off spend down amounts, like dialysis units and other big providers often do. The patient will be responsible for taking medical bills to their Medicaid caseworker to meet the spenddown.
    - ❖ Patients need to know how much their spenddown amount is, which bills can be used to cover it, how to get the bills to the right person, and that copays on services are their responsibility if used toward spenddown. The supplemental services which are through Medicaid are not available when the spenddown is not met, e.g., transportation.
    - ❖ A high spend down is not much different from only having Medicare coverage. If you can't meet your spend down, you don't have Medicaid.
- Some providers do not accept Medicaid.

SOCIAL SECURITY DISABILITY (SSD) and SUPPLEMENTAL SECURITY INCOME (SSI)

A person's disability status can be reassessed 12 months after a transplant. If the kidney is working well, there are few circumstances where a transplant team will certify ongoing disability status. Having a transplant, diabetes, and/or hypertension does not guarantee disability. Functional limitations are critical here.

- If a person has other medical conditions which prevent him/her from working, it is important to continue to see doctors for that condition as well so that provider can comment on disability status.
- The person should REALLY think about returning to work.

MISCELLANEOUS EXPENSES

- Transportation to the transplant center (including parking) can be expensive, especially in the immediate postoperative period due to the frequency of the visits.
- The clinic visits can make for long days and it is not uncommon for patients to buy food at the hospital that day which can add up.

- If they do not live close to the transplant center, there may be housing expenses for the patient and/or family members.
- There will be several new medications started at the time of transplant and typically there are more prescription copays, especially right after transplant.
- The testing to remain active on the transplant waiting list will need to be updated regularly (typically annually), so the out-of-pocket expenses experienced will continue to add up while waiting for a kidney.

It's important to make sure patients understand their responsibilities both before and after transplant. Patients have to let us know that they are having trouble managing their care… we aren't mind readers and we see them with much less frequency over time.

Veteran's Administration (VA) Benefits

Lara Tushla, MSW, LCSW, NSW-C

Healthcare benefits may be available to people who have served in the active military services and who were discharged or released under conditions other than dishonorable. For more information, visit **www.va.gov** or call **877-222-VETS (8387)**.

Duty Requirements:

- Veterans enlisted after September 7, 1980 must have served for 24 continuous months or the full period they were called to serve.
    - ❖ *Does not apply if they were discharged for a disability incurred or aggravated in the line of duty, for a hardship or "early out," to those who served before the above date.*
- Some circumstances can offer enhanced eligibility.

First step is to apply which can be done by completing the VA Form 10-10EZ, Application for Health Benefits online. Information is updated annually through the same site: https://www.1010ez.med.va.gov/sec/vha/1010ez/ or by calling **877-222-VETS (8387)**.

Veterans Health Benefits Guide:
http://www.va.gov/healthbenefits/assets/documents/publications/IB-10-465_veterans_health_benefits_guide_508.pdf

Once the application is processed, the veteran will be assigned an enrollment Priority Group. There are 8 categories based on the connection to the person's military service, disability, receipt of military honors, and financial circumstance. Some veterans will have copays for services depending on the Priority Group.

Pharmacy benefits are available. There are copays for the medications; the drugs must be on the VA formulary, and they have to be ordered by a VA provider.

The VA has 6 centers that can perform kidney transplants. Locate them here:
http://www.va.gov/TRANSPLANT/Transplant_Services_Text_Version.asp

It can be possible for the VA to pay for services outside of the VA system, but it needs to be approved prior to the service being provided except in cases of emergency.

Federal Benefits for Veterans:
http://www.va.gov/opa/publications/benefits_book.asp

Some veterans may be eligible for a pension if they meet certain low income guidelines, are totally disabled, or are over 65. They have to have served for at least 90 days, at least one during a period of war. This is a different process than someone who has a service-connected disability. Veterans who entered active duty after September 8, 1980 may have different time guidelines.

COBRA Info

Lois Kelley, MSW, LSW, ACSW, NSW-C

How Can I Keep My Insurance if Things Change with My Employment Status?

What's COBRA and what's it to me?
COBRA is not the name of an insurance plan. It is the acronym for a law that requires employers to offer to let you keep your insurance AFTER a qualifying event would otherwise cause your insurance to drop. COBRA is the acronym for **C**onsolidated **O**mnibus **B**udget **R**econciliation **A**ct of 1986, which provides for continuation of group health insurance to qualifying individuals, when it might otherwise have been terminated.

What does it take to get COBRA?

1. Employer group health plan coverage (EGHP)
2. Employer with 20 or more employees
3. Qualifying event (QE)
4. COBRA election papers from employer/benefit administrator within 14 days of QE
5. Sign and return the election form within 60 days of the date of the letter
6. Pay the initial premium within 45 days of the signature date

What does it take to get the 11 month extension?

1. Disability determination by social security
2. Provide a copy of the SSA disability ruling letter and a request for the 11 month extension to the employer/benefit administrator within first 60 days of COBRA and prior to the end of the 18 month period.

COBRA coverage will start the date of the qualifying event, and continue for the allowed period of time as long as the premiums are paid on time.

- *If you have Medicare in place before COBRA, the COBRA will continue for the allowed period.*
- *If you get Medicare after COBRA is in place, the COBRA can terminate.*

Important Things for Patients to Remember

1. Check your mail and open letters daily.
2. Keep in touch with your employer's Human Resources Department. They can answer questions about your rights, your benefits, and timelines.
3. Talk to your dialysis social worker if you have any questions or concerns about your insurance, your work, leave from work, short or long-term disability issues.

COBRA, BY THE NUMBERS

Important Numbers for Employers:

- Employer has **30** days to report the "qualifying event" to the health plan.
- Employer has **14** days to send Employee the COBRA election papers after a qualifying event has been reported to the insurance plan.
- Employer must offer COBRA to at least **5** categories of people who were covered at the time of the "qualifying event." These include: former Employees, retirees, spouses, former spouses, and dependent children.
- Employer who has **20 or more** Employees for **50%** or more of its typical business days, and who offers EGHP to Employees, is required to offer COBRA. Some states also require a mini-COBRA if the Employer has **less than 20** employees, and length of COBRA offered is state-specific.

Important Numbers for Employees or Insured Family Member

- Employee has **60** days to report a "qualifying event" to the employer or health plan [e.g., divorce, separation, child ceasing to be dependent under plan rules (age of child)].
    - ❖ *If the Employee is not the person needing COBRA, the Employee may need to notify the employer that COBRA is needed by a dependent. Each of the insured has a right to elect COBRA on an individual basis.*
- Employee/Insured has **60** days to decide to elect COBRA and return the signed election form.
- Employee/Insured has **45** days (from date of signature on election form) to make the initial premium payment on the COBRA policy, which must be paid up to current time.
- Employee/Insured has **30** day grace period to make premium payment (after the initial payment) without losing coverage.
- Employee/Insured can keep a COBRA policy for **18** months.
- Employee/Insured can get an **11** month extension of COBRA (totaling **29** months), when determined to be disabled within the first **60** days of COBRA continuation coverage.
    - ❖ *Send Social Security ruling letter within **60** days of receipt, but prior to expiration of the **18**-month period.*
    - ❖ *If these requirements are met, the entire family qualifies for **11** month extension.*
- Employee dependents can be covered for a maximum of **36** months.
- Employee/Insured pays up to **102%** of the cost of the policy during the **18** months under COBRA.
- Employee/Insured pays up to **150%** of the cost of the policy during the **11** month extension period.

COBRA and MEDICARE

- If a person obtains Medicare before they sign COBRA election forms, the COBRA policy will stay in effect as long as premiums are paid on time or paid within the grace period.
- If a person has COBRA before they become entitled to MEDICARE, the COBRA policy can terminate. Pay special attention to dates of forms and applications and signatures during this process.

Qualifying Events

- **Employee**: termination for reasons other than gross misconduct, reduction of # hours, which might disqualify Employee to participate in group insurance plan.
- **Spouse**: the above, ***plus:*** **(1)** covered Employee's becoming entitled to Medicare, **(2)** divorce or legal separation, **(3)** death of covered Employee.
- **Dependent Children**: all of the above ***plus*** loss of dependent child status under plan rules.

Helpful Websites

- http://www.kidney.org/professionals/CNSW/pdf/COBRA_Fact_Sheet.pdf
- http://www.dol.gov/ebsa/faqs/faq-consumer-cobra.html
- http://www.dol.gov/ebsa/faqs/faq-healthcarereform.html
- http://www.dol.gov/ebsa/publications/cobraEmployee/Insured.html
- http://www.healthcare.gov/
- http://www.dol.gov/ebsa/COBRA.html

Coordination of Benefits (COB)

Marcia Sawyer, LMSW, ACSW

Insurance says:
"You pay!"

Medicare says:
"No! You Pay!"

Coordination of benefits (COB) is a system used in group health plans to eliminate duplication of benefits when you are covered under more than one plan, such as Medicare and a group health plan through your employer. The plans must coordinate to know who pays when and how much each plan is responsible for paying (i.e., which plan has primary payment responsibility).

If a person has insurance through his or her employer, by law, it must pay as the primary insurance for the first 30 months after the patient becomes eligible for Medicare due to ESRD. When the 30 months is up, Medicare begins to pay as primary. The date of the change in who pays first is called the *COB date* or the *flip date*. *Coordination of Benefits does not apply to individual insurance plans. It only applies to employer group health plans.

Patients might be asked to call their insurance company and explain to them that although they DO have Medicare, Medicare will not be primary payer until the 30 month COB period is up. At that point, if patients keep their insurance through their employer, it will pay the 20% that Medicare does not cover for outpatient services like dialysis.

What is Coordination of Benefits?

Health insurance companies use rules to decide which insurance pays medical claims first. These rules are called Coordination of Benefits.

You can reduce delays in getting your medical bills paid by understanding the order in which your insurances pay claims.

What happens if my insurances have the wrong one listed as Primary?

Your insurances will not pay any claims if there are gaps or mistakes in information about your insurance or insurance Coordination of Benefits in their records. When health providers cannot get your insurance to pay claims—they bill you instead.

Why can't insurance companies correct my Coordination of Benefits themselves?

Only you can change the information your insurance companies have on file.

How does having dialysis or a transplant affect my Coordination of Benefits?

To reduce Medicare costs, Medicare requires Employee Group Health Plans to pay Primary for the first 2½ years a person has dialysis or a kidney transplant. Your treatment method defines how long your Employee Group Health Plan stays Primary.

- If you start **Home Dialysis** training within 3 month of beginning dialysis, your Employee Group Health Plan is Primary for 30 months.
- If you start **In-Center Hemodialysis**, your Employee Group Health Plan pays Primary for 33 months.
- If you get a **Kidney Transplant**, you start a new Coordination of Benefits period. Your Employee Group Health Plan is Primary for 30 months.

What is COBRA?

A COBRA is an Employee Group Health Plan that you can keep for up to 3 years after you leave a job by paying for the insurance yourself. COBRA is costly but can still save you money. Group Health insurances often have better coverage than you can get on your own.

Does having COBRA affect my Coordination of Benefits?

COBRA is an EGHP and the same rules apply—with one exception.

You can apply for Medicare as a dialysis or transplant patient when you have an EGHP. People with less than 100% coverage on their EGHP insurance can benefit from having Medicare as a Secondary Insurance.

However, if you sign up for Medicare once you are on COBRA, you can lose your right to COBRA coverage. Only if you had Medicare before getting COBRA can you keep both Medicare and COBRA.

When should I apply for Medicare if I have an EGHP or COBRA insurance?

If you have full insurance coverage with no maximum benefits, apply for Medicare before your EGHP Coordination of Benefits Period or COBRA coverage ends. However, be sure that Medicare starts when your EGHP Coordination of Benefits period or your COBRA coverage ends.

Does Medicare ever pay Primary over an EGHP?

Medicare is Primary over Employee Health Plan Coverage in these cases:

- You lose your Employee Group Health Plan coverage.
- You retire and are over 65.
- You get Social Security Disability Income and Medicare for Disability benefits before you start dialysis.

Are Medicare Supplemental Policies or Medicaid ever Primary?

A Medigap or Medicare Supplement is always secondary to Medicare. Medicaid always pays last after all other insurances are billed.

If I have Medicaid and everything is covered, do I need to apply for Medicare?

- Yes. Medicaid can stop paying all claims until you apply for Medicare and get an answer from Social Security in writing.
- Medicare and Medicaid combine provide you much better coverage than Medicaid alone. You may qualify for a program to pay the Medicare premium.
- If you do not qualify for Medicare, you may need the Medicare as proof so Medicaid will continue to cover your medical care.

What is Medicare Part D?

Robin Asick, MSW, LSW

The Medicare prescription drug plan offers a choice of prescription drug plans that offer various types of coverage.

How do I know if I should enroll in a Part D Plan?

If you have a current plan that is on average as good as Medicare's drug coverage, you may choose not to enroll in a Part D plan. If you have no coverage, or your current coverage is not as good as Medicare's drug coverage, you could join by the deadline to ensure enrollment and avoid late penalties.

How do I enroll in a Part D program?

If you have Medicare, you will get mailings about joining during open enrollment. Open enrollment is typically held during the last 3 months of the year. You may also join when you are first enrolled in Medicare as well.

How do I pay for the Part D premium cost?

A low income subsidy exists to help cover the cost of the Part D premium. You may be eligible for the Extra Help program if you have limited income, have Medicaid/Medical Assistance/Access card and/or receive assistance with payment of your Medicare Part B premium. You can apply on line at www.ssa.gov or call Medicare for assistance at 1-800-633-4227.

What is the Low Income subsidy/Extra Help program?

Persons with full income subsidy have no monthly premium, no annual deductible and no doughnut hole. Only small copayments apply, and have no copays once the out of pocket costs total a certain amount. Partial subsidy also helps with paying premiums and annual deductible is reduced. No doughnut hole exists and copayments for drugs are limited.

What if my state has a drug assistance program?

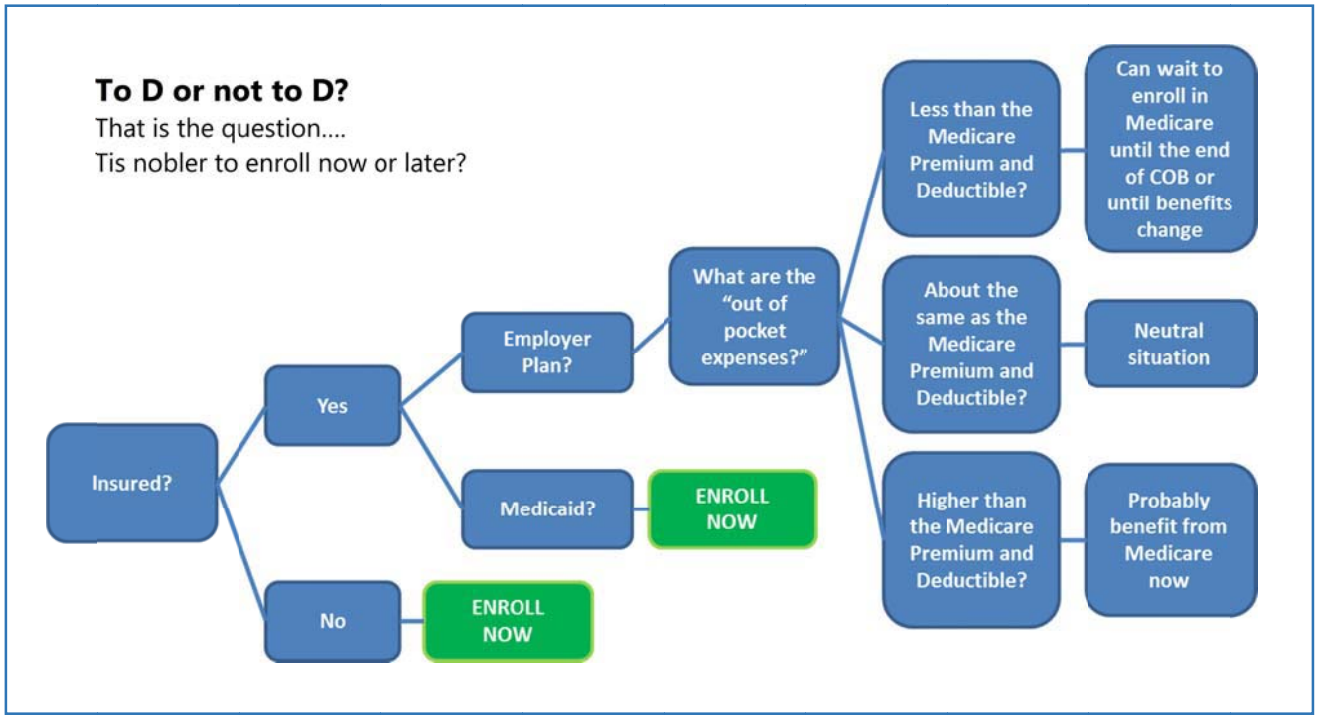
State programs help seniors, disabled and people with kidney disease and often times work with Medicare drug coverage. These programs are not considered credible coverage and would typically supplement Part D programs not replace it.

Will all my medications be covered?

There are many plan choices based on the region where you live. You can call Medicare or go online and enter the names of your medications you take currently to choose that plan that covers most of the drugs you take.

Where can I find the answers to more questions?

You can talk with your social worker, or call your local Department of Aging, call Social Security at 1-800-772-1213 or visit the websites www.medicare.gov, or www.ssa.gov.



Commercial Insurance and ESRD: Definition of Terms

Denise Collins, MSSW, LCSW-C, LICSW, NSW-C

Types of Commercial Insurance:

- **Indemnity**: 80/20 plans
- **Preferred Provider Organization (PPO)**: A health insurance plan that offers greater freedom of choice than HMO plans. Members of PPOs are free to receive care from both in-network or out-of-network (non-preferred) providers, but will receive the highest level of benefits when they use providers inside the network. Using out of network providers will be more expensive
- **Health Maintenance Organization (HMO)**: A healthcare financing and delivery system that provides comprehensive healthcare services for enrollees in a particular geographic area. HMOs require the use of specific, in-network plan providers. *(Check the rules and the EOC; some HMOs do not cover dialysis outside the service area meaning NO TRAVEL similar to Medicaid.)*

Group coverage means coverage through an employer which is, sometimes subject to a waiting period.

Important Terms:

Premium: The amount you or your employer pays each month in exchange for insurance coverage.

Deductible: The amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying.

Coinsurance: The amount you pay to share the cost of covered services after your deductible has been paid. The coinsurance rate is usually a percentage. For example, if the insurance company pays 80% of the claim, you pay 20%.

Copayment: One of the ways you share in your medical costs. You pay a flat fee for certain medical expenses (e.g., $10 for every visit to the doctor), while your insurance company pays the rest.

- *A word about co-payments and co-insurance:* Find out if your dialysis company bills the patient for the co-pay/co-insurance. Not all do; if they do, often, this may not be discussed upfront and the patient may be unpleasantly surprised with a bill for 3 months of co-pays! Knowing this will help the patient to decide whether to get Medicare during the Coordination period. Say, for instance, someone has a $40 co-pay for specialty insurance and chooses hemodialysis. That comes to $120 week and $480 month, which is considerably more than a Medicare Part B premium. Now, what if that same patient chooses peritoneal dialysis and only pays that co-payment once per month? Purchasing Medicare Part B may not be as attractive.

Out-of-Pocket Maximum: The most money you will pay during a year for coverage. It includes deductibles, copayments, and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Allowable Charge: Sometimes known as the "allowed amount," "maximum allowable," and "usual, customary, and reasonable (UCR)" charge, this is the dollar amount considered by a health insurance company to be a reasonable charge for medical services or supplies based on the rates in your area.

Drug Formulary: A list of prescription medications covered by your plan.

Explanation of Benefits (EOB): The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.

Coordination of Benefit (COB): A system used in group health plans to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100% of the claim.

- If you have coverage under your own employer and your spouse, your employer is primary
- If your child has coverage through you and your spouse, the parent with the earliest birth month pays first.
- Coordination with Medicare is subject to specific rules:
  - ❖ Purchasing Part B when you are eligible or at the end of the COB period is not mandatory under the law, but it may be a requirement of your employer/insurer.
  - ❖ Look for Medicare language in your EOC (Evidence of Coverage) or Certificate of Insurance

Out-of-Pocket Costs: The total you pay out of your pocket for a policy year. These costs include the deductible, co-insurance and amounts considered by the insurance company to be above the "Usual and Customary charges

Usual and Customary Charges (also called "**Reasonable and Customary Charges**"): The routine charge for a medical service by similar professional medical providers in the same geographical area.

Certificate of Insurance: A printed description of the benefits and coverage provisions forming the contract between the carrier and the customer. It discloses what is covered, what is not, and dollar limits.

Guaranteed Issue: Refers to health insurance coverage that is guaranteed to be issued to applicants regardless of their health status, age, or income—and guarantees that the policy will be renewed as long as the policy holder continues to pay the policy premium.

Lifetime Maximum Benefit (or Maximum Lifetime Benefit): The maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

Maximum Dollar Limit: The maximum amount of money that an insurance company (or self-insured company) will pay for claims within a specific time period. Maximum dollar limits vary greatly. They may be based on or specified in terms of types of illnesses or types of services. Sometimes they are specified in terms of lifetime, sometimes for a year.

Out-of-Plan (Out-of-Network): This phrase usually refers to physicians, hospitals or other healthcare providers who are considered nonparticipants in an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual's insurance company.

Qualifying Coverage: Refers to individual or employer-sponsored comprehensive group health coverage, but also includes: Medicare, medical assistance, the Indian Health Service and other coverage. Qualifying coverage does not include health benefits for a specific illness, such as cancer, or limited need such as no-fault automobile, disability coverage, dental coverage or other limited-coverage plans.

Affordable Care Act (ACA): Introduction to Terms

Denise Collins, MSSW, LCSW-C, LICSW, NSW-C

For more on the Affordable Care Act, visit: www.healthcare.gov

Three Ways to Save:

1. **Premium assistance**:
    - Up to $45,960 for individuals
    - Up to $62,040 for a family of 2
    - Up to $78,120 for a family of 3
    - Up to $94,200 for a family of 4
    - Up to $110,280 for a family of 5
    - Up to $126,360 for a family of 6
    - Up to $142,440 for a family of 7
    - Up to $158,520 for a family of 8

2. **Lowering of out of pocket costs**, such as co-payments, deductibles and co-insurance for essential health benefits
    - Up to $28,725 for individuals
    - Up to $38,775 for a family of 2
    - Up to $48,825 for a family of 3
    - Up to $58,875 for a family of 4
    - Up to $68,925 for a family of 5
    - Up to $78,975 for a family of 6
    - Up to $89,025 for a family of 7
    - Up to $99,075 for a family of 8
    - CAN ONLY BE USED WITH SILVER PLANS

3. **Medicaid or CHIP**: income limits set by state

Terms:

Health Insurance Marketplace(s) (formerly Health Insurance Exchange(s)): Government-run online markets where individuals and small businesses will be able to compare and enroll in health plans, get answers to questions, and find out if they are eligible for financial assistance or special programs.

Health Plan Categories: Plans in the Marketplace are primarily separated into 4 health plan categories—***Bronze, Silver, Gold, or Platinum***—based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. The plan category you choose affects the total amount you'll likely spend for essential health benefits during the year. The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum). This isn't the same as coinsurance, in which you pay a specific percentage of the cost of a specific service.

Cost Share: The portion of charges for a service or prescription that the member is responsible for paying, such as a copayment, coinsurance, or deductible payment.

Deductible: The fixed amount you must pay in a calendar or contract year for certain healthcare services before your health insurance begins to pay.

Out-Of-Pocket Expenses: Includes copayments, coinsurance, and deductible payments for healthcare services you receive, as opposed to the premium you pay each month to your insurer.

Grandfathered Individual Health Insurance Policy: A policy that you bought for yourself or your family (*and is not a job-related health plan*) on or before March 23, 2010.

Summary of Benefits and Coverage (SBC): A plain-language summary of your benefits and coverage. In compliance with the ACA, every insurer must supply this document and a uniform glossary of common health terms to members and prospective members during open enrollment and/or upon request. The SBC provides a brief summary of information such as the following:

- Cost sharing for some common medical services such as office visits or lab tests
- Deductibles and out-of-pocket limits
- Services not covered by the plan

Subsidy: Financial assistance the government may provide to help some people pay for health coverage or care. The government will pay part of the premium directly to the health plan, usually determined by income level and family size.

Essential Health Benefits: These benefits include at least the following items and services:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization
- Maternity and newborn care (care before and after your baby is born)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

Preventive Health Services for Adults, Women and Children:

- Preventive Care Benefits: Preventive care helps you stay healthy. A doctor isn't someone to see only when you're sick. Doctors also provide services that help keep you healthy.
- Free Preventive Services: All Marketplace plans and many other plans must cover the following list of preventive services without charging you a copayment or coinsurance. This is true even if you haven't met your yearly deductible. This applies only when these services are delivered by a network provider.
- https://www.healthcare.gov/what-are-my-preventive-care-benefits