NORD National Organization for Rare Disorders | CLAIM YOUR Care

Increasing Knowledge of Rare Disease Health Care Coverage

Open Enrollment Tips

It's important to enroll in a health insurance plan every year. It's also important to choose an insurance plan that best meets the needs of you and your family. Whether you decide to obtain your coverage through Medicaid, Medicare, or your employer, reviewing the options can be stressful and overwhelming.

Here are some steps to help you simplify the decision-making process and lessen your stress as you select a plan for you and your family.

Step 1. Learn Commonly-Used Health Coverage Terms

Health insurance plans typically include several important terms and provisions intended to describe types of plans, coverage, costs, benefits, limitations and exclusions. A few examples of these key terms are listed below:

- **Essential Health Benefits:** A set of healthcare service categories that must be covered by certain plans. Defined by the Affordable Care Act, essential health benefits include, but are not limited to, the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services.
- **Coordination of Benefits:** A way to figure out who pays first when two or more health insurance plans are responsible for paying the same medical claim.
- **Provider Network:** A list of doctors, other health care providers, and hospitals that a plan contracts with to provide medical care to its members.
- **Preferred Drug List (PDL):** A PDL is a list of medications that an insurance plan covers at lower costs. A PDL is part of the plan's formulary, which is a broader list of all covered medications. If a medication is not on the PDL, you may have to pay more or get an exception approved by your insurer to obtain the drug.

Step 2. Assess Your Health Care Needs

Consider what kind of care you and your family need.

- **Doctor visits per year:** If you or your family have multiple doctors and/or specialists and usually make frequent visits to the doctor, look into a plan with a low copay.
- **Use of prescription medications:** How many prescription medications does your family purchase on a regular basis? It's also important to know which medications your family uses and if these medications are covered under the plan you choose. Some plans cover more medications than others.
- **Specialized care:** Some conditions require specialized care and/or treatment. It is important to know if this applies to anyone in your family who will be covered under your health plan and which plan will cover these needs.

Step 3. Compare the Costs

When you compare plans, it is important to understand how much of the cost you are responsible for versus what the plan will pay.

- **Premium:** This is the amount you pay each month to keep your insurance. Even if you don't visit the doctor during a particular month, you will still be required to pay. Higher premium plans often have lower deductibles.

- **Deductible:** This is the amount you must pay each year before the insurance begins to lower your costs. A higher deductible usually means a lower monthly premium. If you're healthy and don't need much care, a high-deductible plan may save you money.
- **Copayment (copay):** This is a fee you may be required to pay each time you visit your doctor or pick up a prescription. In some plans, a copay may also be required for health-related testing, such as bloodwork or X-rays.
- **Out-of-pocket maximum:** If you have a lot of medical costs in a year, this limit will protect you from having to pay too much.
- **Coinsurance:** This is the percentage of a medical bill you will have to pay after you've reached your deductible and before you have reached your out-of-pocket maximum.

Be sure to compare the total costs for plans you're considering, not just the monthly premiums.

Step 4. Review the Provider Network

- **In-network:** Each health insurance plan has a provider network that lists doctors, hospitals, clinics, pharmacies, and other care facilities that have contracted with the health plan and are considered "in-network," meaning that these providers accept that type of insurance and that your cost to see the provider will be less. If you already have a doctor you like, make sure they're included in the plan's network.
- **Out-of-network:** If you receive care or services from a provider not included in the health insurance plan's network, they are referred to as an "out-of-network" provider. Typically, the copay and coinsurance you will owe to this provider will be higher than an in-network provider. **It is important to note that many health insurance plans do not offer coverage for ANY out-of-network services, which means you will be responsible for 100% of those costs and they will not apply to your out of pocket maximum.**

Step 5. Review the Plan's Summary of Benefits

Each health insurance plan covers different types of care. Look for plans that cover the services you need, such as:

- **Doctor visits and checkups**
- **Prescription medications**
- **Emergency care**
- **Specialist care**
- **Mental health services**

Step 6. Review Extra Benefits (if offered)

Some plans offer extra benefits that may be helpful, such as:

- **Telehealth visits** (seeing a doctor online)
- **Vision or dental care** (for glasses, eye exams, or dental checkups)
- **Wellness programs** (gym discounts or health classes)

Step 7. Use a Checklist to Compare Plans

Make a list of the things you care about most when it comes to your health care insurance plan, whether it's low monthly costs, coverage for medications, or a large network of doctors. Once you've made your list, review each plan and check off the things it offers that mean the most to you.

Step 8. Ask for Help if You Need it

If you are still unsure about which plan to choose, there are resources available to assist you, depending on where you plan to obtain your coverage. Many states offer help to consumers through Consumer Assistance Programs (CAPs). These programs are designed to assist consumers who are experiencing problems with their health insurance or who are looking to learn more about their health care options. CAPs offer direct assistance by phone, direct mail, email, and in person by providing walk-in locations to help consumers learn how to obtain or use their insurance effectively. For more information visit: Consumer Assistance.

Other options for assistance with your health insurance include reaching out to your human resource department if you are getting coverage through your employer, contacting your health insurance provider directly, and communicating with your local or national patient advocacy organizations.

Step 9. Take Your Time

Again, it is critical that you choose a health care insurance plan within the limited open enrollment period, it's also important for you to take time to thoroughly read through the different health insurance plan options and to choose the one that meets the specific needs of both you and your family.

Supported by CSL Behring, Jazz Pharmaceuticals, Inc., Kyowa Kirin Co., Ltd., Novo Nordisk, Inc., and Takeda Pharmaceutical Company Limited.