COMPASS
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## Plan Comparison Checklist

**Date:**

The chart below should serve as a comprehensive guide for users when comparing health insurance plans during open enrollment. This chart is also used by *Compass* case managers during personalized, one-on-one sessions. It is not a requirement to complete the chart before speaking with a *Compass* case manager.

| | | |
|---|---|---|
| State: | Income: $ | FPL: |
| County: | Household Size: | Premium Tax Credit Eligibility |
| Zip: | Website: www.healthcare.gov | ☐ Eligible ☐ Ineligible |
| Type: ☐ Marketplace ☐ Private ☐ Employer | ☐ Family Plan ☐ Individual Plan | Tax Credit Amount: $ |
| Reason for Plan Comparison: ☐ Turning 26 ☐ Premium Cost ☐ Coverage Issue ☐ Involuntary Plan Loss | | |

| | Plan A | Plan B | Plan C |
|---|---|---|---|
| Plan Name | | | |
| Plan ID | | | |
| Type of Network (HMO/PPO/POS/EPO) | | | |
| PCP Referral Required to See Specialist(s)? (Yes/No) | | | |
| Individual Monthly Premium | | | |
| Family Monthly Premium | | | |
| Individual Ded Amount | | | |
| Family Ded Amount | | | |
| Individual OOP Max Amount | | | |
| Family OOP Max Amount | | | |
| All Providers INN? (Yes/No) | | | |
| PCP Office Visit Cost | | | |
| Specialist Office Visit Cost | | | |
| Cost for Diagnostic Testing (e.g., bloodwork, PFT, imaging, etc.) | | | |
| Outpatient Facility Fee | | | |
| Hospitalization Cost | | | |
| Mental Health Cost | | | |
| Home Health Care Cost | | | |
| Durable Medical Equipment | | | |

Abbreviations:

Ded - Deductible
EPO - Exclusive Provider Organization
FPL – Federal Poverty Level
HMO - Health Maintenance Organization
INN - In-Network
LD - Limited Distribution
Max - Maximum
OON - Out of Network
OOP - Out of Pocket Maximum
PA - Prior Authorization
PCP - Primary Care Physician
POS - Point of Service
PPO – Preferred Provider Organization
QL - Quantity Limit
Rx - Prescription
SP - Specialty Pharmacy

## Provider Coverage

| | | | | |
|---|---|---|---|---|
| CF Care Center Name:<br>Plan A: ☐ INN ☐ OON<br>Plan B: ☐ INN ☐ OON<br>Plan C: ☐ INN ☐ OON | Doctor's Name:<br>Plan A: ☐ INN ☐ OON<br>Plan B: ☐ INN ☐ OON<br>Plan C: ☐ INN ☐ OON | Doctor's Name:<br>Plan A: ☐ INN ☐ OON<br>Plan B: ☐ INN ☐ OON<br>Plan C: ☐ INN ☐ OON | Doctor's Name:<br>Plan A: ☐ INN ☐ OON<br>Plan B: ☐ INN ☐ OON<br>Plan C: ☐ INN ☐ OON | Doctor's Name:<br>Plan A: ☐ INN ☐ OON<br>Plan B: ☐ INN ☐ OON<br>Plan C: ☐ INN ☐ OON |

## Prescription Drug Coverage

### Plan A

| | | | |
|---|---|---|---|
| Separate Ded for Rx? (Yes/No) | | If yes, Rx Ded Amount: $ | |
| Does this plan allow copay assistance amount to be applied toward Ded/OOP? | | *This information may be found in the plan's member handbook, or on the insurance company's website. You may need to contact the insurance company (or your HR/plan administrator) directly to obtain this information.* | |
| Product Name | Covered? | Copay/Coinsurance | Drug Restrictions (i.e.,PA, QL, LD, etc.) |
| | | | |
| | | | |
| | | | |

### Plan B

| | | | |
|---|---|---|---|
| Separate Ded for Rx? (Yes/No) | | If yes, Rx Ded Amount: $ | |
| Does this plan allow copay assistance amount to be applied toward Ded/OOP? | | *This information may be found in the plan's member handbook, or on the insurance company's website. You may need to contact the insurance company (or your HR/plan administrator) directly to obtain this information.* | |
| Product Name | Covered? | Copay/Coinsurance | Drug Restrictions (i.e.,PA, QL, LD, etc.) |
| | | | |
| | | | |
| | | | |

### Plan C

| | | | |
|---|---|---|---|
| Separate Ded for Rx? (Yes/No) | | If yes, Rx Ded Amount: $ | |
| Does this plan allow copay assistance amount to be applied toward Ded/OOP? | | *This information may be found in the plan's member handbook, or on the insurance company's website. You may need to contact the insurance company (or your HR/plan administrator) directly to obtain this information.* | |
| Product Name | Covered? | Copay/Coinsurance | Drug Restrictions (i.e.,PA, QL, LD, etc.) |
| | | | |
| | | | |
| | | | |

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# Glossary of Common Health Insurance Terms

Sorting through the various terms and processes involved in choosing the right plan can be overwhelming. To best understand the basics of health insurance, it is helpful to first know some common terms.

**Brand name medication:** A medication marketed under a trademark name or patent. The patent gives a drug manufacturer exclusive rights to produce and sell the medication for a limited time.

**Claim:** A formal payment request that a policy holder or health care provider submits to the policy holder's health insurance company for coverage of care or services.

**Coinsurance:** The cost that the policy holder shares with the health insurance company for covered services, calculated as a percentage. For example, if the policy holder has an office visit that costs $100 before insurance and the plan's coinsurance requirement is 20 percent, the policy holder would pay $20. The health insurance plan would then pay the remaining 80 percent, or $80.

**Co-payment:** A fixed-dollar amount that the policy holder pays for covered health care service. In most cases, copayment do not count toward the deductible, but do count toward the out-of-pocket maximum. Copayments vary between plans and may apply to different health care services, such as urgent care, office visits, or medications.

**Deductible:** A fixed-dollar amount that the policy holder must pay before the health insurance company starts to make payments for covered medical services. Some insurance plans have both individual and family deductibles, while some family health insurance plans may have only a family deductible. Deductibles may apply only to specific services and may not apply to office visits or prescription medications. Under the Affordable Care Act, deductibles do not apply to preventive care (such as annual exams and immunizations) and routine gynecological visits.

**Drug formulary:** A list of prescription medications covered by a health insurance plan. Formularies can be open (little or no limitation on the medications covered), closed (coverage is limited to the medications contained in the formulary), or restricted (some flexibility in medication choice).

**Exclusion or limitation:** A service that a health insurance plan does not cover.

**Explanation of benefits (EOB):** A statement that is produced by the health insurance company describing how a claim was paid based on the benefits outlined in a plan.

**Generic medication:** A medication that is manufactured by a company that did not create the brand name medication. Generic medications are chemically equivalent to the brand name medications and have been approved by the U.S. Food and Drug Administration (FDA), but are less expensive.

**Health insurance network:** The facilities, providers, and suppliers that the health insurance plan has contracted with to provide health care services at a pre-negotiated rate.

**In-network provider:** A health care provider who is contracted with the health insurance plan to provide services to policy holders for specific pre-negotiated rates while also meeting quality standards.

**Mail-order pharmacy**: A type of pharmacy that fills prescriptions and sends medications to customers via mail. Some health insurance plans offer lower copays if a 90-day supply is ordered through the mail-order pharmacy. Please note: pharmacy benefit managers are restricted to using certain mail-order pharmacies of their choice.

**Managed care:** A health care plan or system that seeks to control medical costs by contracting with a network of providers.

**Non-preferred medication:** An alternative that may be prescribed instead of a preferred medication. Usually, non-preferred medications are associated with higher copayments. These medications are often restricted, meaning that they require a prior authorization or are excluded from a drug formulary completely.

**Open enrollment:** A window of time during which individuals and employees may add or drop their health insurance plan or make changes to existing coverage.

**Out-of-network provider**: A health care provider who is not contracted with the health insurance plan. Typically, the health insurance company pays either, less or nothing at all, for services received from out-of-network providers.

**Out-of-pocket maximum:** The maximum amount that the policy holder can spend for covered services in a set coverage period. After the out-of-pocket maximum is reached, the health insurance plan pays for all covered services for the remainder of the coverage period.

**Pharmacy benefits manager:** A third-party administrator contracted by health insurance plans for processing and paying prescription medication claims. Pharmacy benefits managers are primarily responsible for developing and maintaining the drug formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers. They also offer value-based programs to participants, such as medication therapy, disease management, and assistance with mail-order pharmacies.

**Preferred medication**: A medication listed on the health insurance plan's drug formulary or preferred list of prescription medications. These medications may cost more than generics but less than non-preferred brands.

**Premium:** A monthly amount paid by the policy holder to purchase a health insurance plan for a specific benefit period. A premium must be paid to keep the coverage active, regardless of whether the policy holder seeks care. Failure to pay the premium by the due date may result in termination of the health insurance policy. It is helpful to note that for employer-sponsored group plans, the employer pays a portion of the premium and the remainder is deducted from the employee's (policy holder's) paycheck. Most insurers require employers to contribute at least half of the premium cost for covered employees.

**Primary insurance:** The health insurance plan that pays first on a claim when a person is covered under more than one health insurance plan.

**Prior authorization:** A formal review and approval process conducted by a health insurance company before it will agree to cover a service, medication, or prescription fill.

**Reauthorization:** A renewal of the prior authorization on file. Since most prior authorization approvals are only valid for a certain period, an insurer might ask the policy holder to periodically submit medical records that show improvement in health or require a specific form.

**Reimbursement:** The system through which the insurer pays health care providers for services given to the policy holder.

**Retail pharmacy:** A local pharmacy (such as a CVS, Walgreens, or a grocery store pharmacy) that has a state license to dispense medications. Retail pharmacies are usually limited to filling prescriptions for 30-day supplies. Pharmacy benefit managers may also have restrictions limiting use of certain retail pharmacies chains.

**Secondary insurance:** A health insurance plan that provides claims payments after a primary health insurance plan if an individual is covered by more than one insurance company.

**Special enrollment period:** A time outside the open enrollment period where an individual can still sign up for health insurance. An individual may qualify for a special enrollment period during certain life events or unusual circumstances, and usually have up to 60 days following the event to enroll in a plan.

**Specialty pharmacy:** A pharmacy that typically serves members who have rare and chronic diseases. These pharmacies focus on high-cost biotech drugs such as injectable or inhaled medications; provide value-added services such as refill reminders, overnight deliveries, and the ability to track prescription status online; and provide therapy management over the phone to ensure safety and compliance. Medications from specialty pharmacies often need to be handled and stored in a particular way to maintain effectiveness and are unavailable at local retail pharmacies.

**Step therapy:** A type of prior authorization that requires a doctor to show clinically that a policy holder has tried and failed taking a less expensive or a preferred medication on the formulary before a health insurance plan will cover the prescribed medication.