Benefits Assessment Guide

Selecting a comprehensive health plan that will meet your coverage needs when you have a chronic illness is vital. In cystic fibrosis not having access to your medications or providers can have lasting negative implications on your health. Always make sure that you let the CF clinic know of any changes to your insurance so they are able to make sure that you have authorization in place for needed medications and therapies.

Use this guide to help select a health plan that offers comprehensive coverage for CF-related care and to understand existing coverage.

When selecting a health plan, keep the following general trends in mind:

- Lower premium = higher out-of-pocket cost
- Higher premium = lower out-of-pocket cost

To find out if you are eligible for Medicaid (AHCCCS) in the state of AZ visit:
https://www.azahcccs.gov/Members/Downloads/EligibilityRequirements.pdf
The AHCCCS plan that provides the best coverage for patients with CF is: United Healthcare Community Plan
Medicaid DOES cover CF therapies/medications, doctor visits, and lung transplants (at in states centers) at 100%

If you are on Medicare CF medications can be quite expensive as all nebulized therapies are billed under your Medicare part B, rather than through your Medicare prescription plan (part D) and you are not able to use pharmaceutical copay cards. Under part B members are usually responsible for about 20% of the cost which can be hundreds to thousands of dollars per month for medications like Pulmozyme or inhaled Tobi. To assist with these out of pocket costs you may want to investigate if a Medicare supplement or replacement plan would be beneficial. The Area Agency on Aging 602-280-1059 has Medicare specialists on their Benefit Assessment Team that can help you navigate your options. This service is free. Also ask your CF team if you may be eligible for assistance through the Healthwell grant to help cover some out of pocket prescription costs. Eligibility is based on income.

Under the Affordable Care Act (ACA) patients are able to stay on their parent's health insurance until age 26. After age 26 you may still qualify to stay on their plan if you meet certain criteria as an adult with a disabling disease who would otherwise not be able to maintain gainful employment and benefits, and who does not qualify for state Medicaid. To explore this option your parent would need to speak with their HR team. It usually involves your provider filling out a form for your insurance plan certifying this information.

The CF Foundation Compass Program will also help you investigate insurance plan. This is especially helpful if you are looking at plans through the marketplace (healthcare.gov) as they will investigate and compare 3 different plans to help you choose the best fit. To speak with compass please call 844-266-7277 or email them at compass@cff.org

CF providers, patients and families should ask the following questions when selecting a health plan

COST-RELATED QUESTIONS

- ***How much is my monthly premium?***
- ***Will I have to pay an annual deductible?***
  An annual deductible is the amount a patient must pay out-of-pocket prior to plan payment.
- ***Do prescription costs count towards my deductible?***
  **If the answer to above is yes, then patients on commercial insurance plans may be able to get help with this cost by filling medications that have copay assistance programs early in the plan year (Orkambi, Pulmozyme, Creon, ZenPep, Bethkis, Tobi Podhaler, Cayston, etc), often these copay programs will cover your out of pocket cost up to a certain amount. Please contact that CF clinic with questions about copay assistance programs. Patients on Medicare, Medicaid or Tricare are not eligible for pharmaceutical company copay programs, but may be eligible for assistance through the Healthwell Foundation.
- ***How much is my co-payment for visits to my primary care physician (PCP) or specialist?***

- ***Do I need a referral to see a specialist?***
  This means that a PCP would need to send a paper referral in order for your visits to be covered.
- ***Are my care providers in network? You can have the plan look this up by the facility Tax ID number***
  Phoenix Children/s Medical Group (this is the outpatient clinic): Tax ID 201291415
  Phoenix Children's Hospital: Tax ID 860422559
  For adults, see if Banner University Medical Center is in network: Tax ID 270036499
  **If your only coverage option does not have PCMG/PCH in network please let the clinic know asap so that we can assist with trying to get out of network authorization for outpatient visits if your plan allows this. If this is an employer based plan you may speak with your HR department about network status since there would not be an "in-network" option for a CF center in this area and care at an accredited CF care center is the standard of care for patients with cystic fibrosis.
- ***What if I go to an out-of-network emergency room? What if I get admitted from the ER to that facility?***
  Typically the ER visit and the admit would be covered as long as you are going to the ER for a true emergency (ie: shortness of breath, hemoptysis, chest pain,etc) rather than a complaint that could have been handled by your PCP or an Urgent Care (ie: sore throat, UTI, etc).
- ***How much will I pay if I choose to go to an out of network doctor or facility for non-emergency services?***
- ***How much will I pay for brand-name drugs? How much for generic drugs?***
  You may want to see if the medications that you use are on the plans formulary, if not what is the process to get approval for a non-formulary medication?
- ***Do I have to use a mail order pharmacy for maintenance medications?***
  Is there an option to use a local retail pharmacy instead since most mail order pharmacies will not accept copay assistance cards?
- ***How much will I pay for a hospital stay or an emergency visit?***
- ***How much will I pay for outpatient services such as labs or imaging?***
- ***How much will I pay for home health services such as nursing or home IV therapy?***
  Typically patients on Medicare and Tricare are not able to do home IV antibiotics unless they are considered "homebound" under Medicare guidelines (this usually means limited mobility, on home oxygen, not working or going to school).
- ***Is there an annual out-of-pocket maximum?***
  An out-of-pocket maximum can limit the patient's financial burden. After paying a certain amount, not including premiums, the health plan will pay the full cost of care during the plan year.
- ***Does the out-of-pocket maximum apply to my prescription and major medical portion of my plan together or do prescription and major medical benefits have separate out-of-pocket maximums?***