

GLOSSARY

Co-insurance: Your share of the total cost of a covered healthcare service, calculated as a percent (for example, 20%).

Co-payment: A fixed amount (for example, \$15) that you pay for a covered healthcare service.

Deductible: The amount you must pay for healthcare services before your health plan begins to pay for them. For example, if your deductible is \$1,000, your plan will begin to pay for benefits after you have met your \$1,000 deductible.

Essential health benefits: Broad categories of items or services that Marketplace plans must cover. Prescription drugs are 1 of 10 essential health benefits, but a plan is not required to cover all prescription drugs.

Formulary: A list of medications that a health plan will cover.

Health Insurance Marketplace: Also called *exchanges*, the Marketplace in each state is an online site that allows people to compare and shop for health insurance coverage.

Plan summary: Also called a *summary of benefits and coverage*, the plan summary allows you to review benefits, costs, and other features and can be used to compare plan options.

Premium: The amount that you pay for your health insurance coverage. Usually, this is paid on a monthly basis.

Provider network: A network of selected healthcare providers (eg, doctors, hospitals, and pharmacies) that contract with a health plan. Some health plans do not provide coverage for services provided outside the network.

Wraparound services: Also known as coordination of services. Wraparound services may involve providing financial support, healthcare benefits, and/or case management services.

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Distributed by: Janssen Therapeutics, Division of Janssen Products, LP, Titusville, NJ 08560
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IDEA

Partnering to Inspire Change through
Insight, Discussion, Empowerment & Advocacy
HEALTH CARE SUMMIT

DRIVING THE **ENGAGED AND EMPOWERED** PATIENT TO ACTION



ENROLLMENT IN THE INSURANCE MARKETPLACE: TIPS AND TOOLS TO HELP YOUR CONSTITUENTS SUCCEED

The Health Insurance Marketplace is an online site where your constituents can compare and buy health insurance plans.

Open enrollment for 2016 is between
November 1, 2015 and January 31, 2016.

This guide can help you answer questions your constituents may have about enrolling in a health plan!

There are 4 basic types of Marketplace plans: **Bronze, Silver, Gold, and Platinum.**

Here are 3 essential questions your constituents must answer when selecting a health plan:





- What can they afford to pay for their benefits?
- Is their doctor in a health plan's network?
- Which prescription drugs do they take?



Janssen Therapeutics does not endorse any health plan. This information is intended to help you answer common questions about choosing healthcare coverage.







TYPES OF PLANS OFFERED IN THE HEALTH INSURANCE MARKETPLACE

The basic difference among plan types is how much your constituent will pay for coverage. In general, the lower their monthly premium is, the higher their out-of-pocket costs will be when they need care.

 Bronze plans	 Silver plans
<ul style="list-style-type: none"> • Lowest monthly premiums • Pay about 40% of healthcare costs • May have high out-of-pocket costs if they visit the doctor frequently or take a lot of prescription drugs 	<ul style="list-style-type: none"> • Higher monthly premiums than bronze plans • Pay about 30% of healthcare costs • Depending on income, they may qualify for help with costs if enrolled in a silver plan
 Gold plans	 Platinum plans
<ul style="list-style-type: none"> • Higher monthly premiums than silver plans • Pay about 20% of healthcare costs • May be a reasonable choice if they need frequent care or take multiple prescription drugs 	<ul style="list-style-type: none"> • Highest monthly premiums • Pay about 10% of healthcare costs • Platinum plans may not be available in every area

Does your constituent qualify for help with insurance costs?

Your constituents may qualify for tax credits and subsidies to offset the cost of paying for health insurance. Eligibility depends on household size and income, and they can only qualify for both lower premiums AND lower out-of-pocket costs if they choose a silver plan.

Number of people in a constituent's household						
						
Marketplace health plans	They may qualify for lower premiums on a Marketplace insurance plan if their yearly income is between...*					
	\$11,670 and \$46,680	\$15,730 and \$62,920	\$19,790 and \$79,160	\$23,850 and \$95,400	\$27,910 and \$111,640	\$31,970 and \$127,880
	If their income is at the lower end of the range above, please see below ▼					
They may qualify for lower premiums AND lower out-of-pocket costs for Marketplace insurance if their yearly income is between...†						
	\$11,670 and \$29,175	\$15,730 and \$39,325	\$19,790 and \$49,475	\$23,850 and \$59,625	\$27,910 and \$69,775	\$31,970 and \$79,925

*Income ranges are higher in Alaska and Hawaii.

†In addition to these income requirements, constituents must choose a silver plan in order to qualify for lower premiums AND lower out-of-pocket costs.

DISCUSSION GUIDE: COMMON QUESTIONS ABOUT SELECTING A HEALTH PLAN

Following are examples of the discussions you may have with your constituents on how to choose the health plan that best meets their needs. Words in *italics* are defined on the back of this brochure.

Can I see my doctor in a Marketplace plan? Some plans allow you to visit any doctor. Other plans will pay for your visit only when the doctor is in their *provider network*. In some states, Marketplace sites do not list a plan's provider network. If a particular doctor is important to you, visit the plan's website and look for its provider network. Or, ask your doctor if he or she sees patients in a particular plan.

How do I know if my prescription drugs are covered? In some states, Marketplace sites show you which medications are covered by each plan. In other states, you may have to visit the plan's website and look for its *formulary*, which is a list of medications the plan will cover. This is important if you take a particular drug, because prescription drug coverage is different from plan to plan.

Is coverage better if I choose a plan in a higher metal, like gold or platinum? In general, metal levels refer to costs, not benefits. All plans in the Marketplace are required to cover certain benefits, called *essential health benefits*. Prescription drugs are an essential health benefit, but not every medication is covered by every plan. When comparing plans, look for a plan summary.

What are my out-of-pocket costs? There are 3 types of out-of-pocket costs: *deductibles*, *co-payments*, and *co-insurance*. The amount you pay for each differs from plan to plan, but out-of-pocket costs are usually higher in lower-premium plans. To compare plans' out-of-pocket costs, look on the Marketplace site for a plan summary.

Is there a limit to my out-of-pocket costs? For most services, yes. In 2016, the annual out-of-pocket limit for essential health benefits is \$6,850 for a single person or \$13,700 for a family. Prescription drugs are an essential health benefit, but it is important to know that if you take a medication that is not covered by your plan, your cost for that medication does not count toward your out-of-pocket limit.

Is there help for me to afford my premiums or out-of-pocket costs? If your annual household income is within a certain range, you may qualify for subsidies or tax credits. Visit www.healthcare.gov for more information. If you do not qualify for Marketplace subsidies or tax credits, you may be able to get help paying for medications through manufacturer-sponsored savings programs or through an independent co-payment assistance foundation.

I enrolled in a Marketplace plan last year that does not meet my needs. Can I switch to a new plan? You may switch plans during the open enrollment period. If you do not enroll in a new plan, you will be automatically re-enrolled in your current plan.