

Getting Started

Step 1

Complete the Personal Health Experience Stat Sheet. This document was designed to identify and quantify the health services used by you and your family in the previous 12 months, providing you with a list of benefits your new plan should include.

Step 2

Have a copy of the Glossary of Commonly Used Healthcare Terms and Acronyms document at hand.

Step 3

Collect from your human resources representative, insurance agent, or Marketplace the following documents for each health plan offered. (Note: often you will be provided a link to this information on the insurance carrier's website)

A) Summary of Benefits and Coverage (SBC) – Health insurers and group health plans are required to provide you with an easy-to-understand summary of a health plan's benefits and coverage. For more information on what should be included in your SBC, please see the fact sheet section of the toolkit. You may also want to get a copy of other plan documents from your plan or employer for information not included on your SBC, including more detail on excluded benefits and plan rules.

B) Drug Formulary – Health insurers maintain a formulary (sometimes referred to as a preferred drug list or PDL), which is a list of prescription drugs, both generic and brand name, that are covered through your plan. Formularies classify drugs by different cost tiers that define the plan member's co-payment (co-pay) amount and/or coinsurance levels. Typically, generic drugs require the lowest co-pay from plan members. Brand name drugs will cost more and specialty tier drugs will cost the most and sometimes require you to meet certain requirements such as "fail first" or step therapy, or prior authorization. The formulary may have that information. However, it must be included in formularies for Marketplace plans.

C) Provider Network Booklet – A provider network is a group of providers (such as physicians, hospitals, skilled nursing facilities, pharmacy or other licensed, certified institutions, or health professionals) that have contracted with the health plan to provide healthcare services to plan members at agreed upon billing rates. Depending on the plan's design, members who receive care from a provider not included in the network may have less or no coverage for that provider and/or service received.

Members who get care out-of-network may also be subject to "balance billing," in which the out-of-network provider charges the patient for his or her charges above what the plan will pay. Please see the fact sheets section of the tool kit for more information on balance billing. It is important to note that many insurers offer several different plan options, each of which may have a different provider network. It is important to review the current provider network for EACH plan.

Step 4

Begin using your Health Plan Cost Comparison Worksheet. One way to evaluate your potential cost is to base your review on your previous year's medical experience. Using the information included on your Personal Health Experience Stat Sheet, the plan's SBC, provider directory, and drug formulary list, fill in each section that applies on the worksheet.

It is important to remember that unexpected medical needs often arise. Their costs are typically unpredictable. The toolkit is designed to provide a general idea of predictable costs associated with your health plan based on your family's known health situations.

While these documents may answer many of the questions important to choosing the appropriate plan, there may be some questions that require additional resources. To answer these questions, begin by contacting your human resources/benefits administration department, broker or your health plan's customer service representative. There are many resources available to consumers who need additional help. For more information and/or a list of available resources, you can contact NHF, your local chapter, and/or your HTC social worker.

