

RESOURCES

BOSTON CHILDREN'S HOSPITAL'S PATIENT FINANCIAL SERVICES CUSTOMER SUPPORT DEPARTMENT:
Boston Children's resource center for finance and billing assistance.
childrenshospital.org/patient-resources/customer-service/financial-and-billing-matters 617-355-3397

COMMONWEALTH OF MASSACHUSETTS' CENTER FOR HEALTHCARE FINANCING ENHANCED COORDINATION OF BENEFITS (ECOB) PROGRAM:
The ECOB works with MassHealth to help supplement its members' health care coverage with private insurance.
ecob@umassmed.edu 800-462-1120 option #5

DISABILITY LAW CENTER:
The Disability Law Center is the protection and advocacy agency for Massachusetts residents with disabilities.
dlc-ma.org 617-723-8455

HEALTHCARE.GOV:
An interactive website that helps with coverage options.
healthcare.gov 800-318-2596

HEALTH INSURANCE RESOURCE CENTER:
A wealth of general and state-specific information, including glossary of health care terms.
healthinsurance.org

MEDICARE.GOV:
The official U.S. government website for Medicare.
medicare.gov 800-633-4227

SOCIAL SECURITY ADMINISTRATION:
Website detailing benefits for people with disabilities.
ssa.gov/disability 800-772-1213

If you do not have insurance and/or are unsure of how to get it, the following resources may be helpful:

HEALTH CARE FOR ALL:
A public organization that provides information on accessing healthcare, legal support, community organizing and public education.
hcfama.org 800-272-4232

MASSACHUSETTS HEALTH CONNECTOR:
A state-based health insurance marketplace that makes shopping for affordable health and dental coverage easier for Massachusetts individuals, families and small businesses.
betterhealthconnector.com 877-623-6765

 **Boston Children's Hospital**
Social Work Department Transition Committee

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Please check with your insurance provider for information specific to your plan and benefits.
For Permissions: Contact Social Work Department Transition Committee
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SWTransition@childrens.harvard.edu



A Young Adult's Guide to Health Insurance

 **Boston Children's Hospital**
Social Work Department Transition Committee

WHAT IS HEALTH INSURANCE?

Health insurance is a way to pay for your health care. It protects you from having to pay the full costs of medical services if you're injured or sick.

NOTE: Each health insurance plan is different and covers different medical costs. If you are 26 or younger, you could have health insurance through your parents' plan. You can also get health insurance through:

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|  Your job |  Private Health Insurance Agencies |
|  College/university plans |  Medicaid or the United States Department of Veteran Affairs (VA) |

WHY IS HEALTH INSURANCE IMPORTANT?

Health insurance is important because it:

PROTECTS YOU from unexpected, high medical costs. Even though you are young—and even if you are healthy—paying the medical costs of an accident or illness could put you in a lot of debt (a situation where you owe a lot of money).

ALLOWS YOU TO PAY LESS for certain health care services associated with your health insurance plan

CAN GIVE YOU ACCESS TO FREE CARE TO PREVENT CERTAIN ILLNESS, like vaccines, screenings and check-ups (however, each plan offers different benefits, so be sure to read about your plan carefully to learn about what is covered for free).

DO I HAVE TO HAVE HEALTH INSURANCE?

It's important to have health insurance. All Americans who don't have health insurance have to pay a tax penalty, meaning you'll have to pay more money back to the government in taxes for not having health insurance. Plus, with certain health insurance plans, you don't have to pay fees that many people who don't have health insurance coverage must pay.

CAN I BE ON MY PARENTS' INSURANCE PLAN?

If your parents have health insurance through their job, you can often stay on their plan until you are **26 years old**. You can often stay on your family's Medicaid plan until you are **19 years old**.

Check with your insurance company if you are unsure whether or not you can stay on your parent's plan.

CAN I JOIN MY PARENTS' MEDICARE PLAN?

No. There's no family coverage on Medicare plans.

WHAT IS MASSHEALTH?

MassHealth is a public health insurance program for people who have low- to medium-income and live in Massachusetts. **Note:** If you have been covered by a MassHealth family plan, when you turn 19 you are considered your own household and you must apply for MassHealth as an individual. See mass.gov/eohhs/gov/departments/masshealth

MASSHEALTH ENROLLMENT CENTERS:

To speed up the process of enrolling in MassHealth, visit a Financial Counseling Office at your neighborhood health center, community hospital or here at Boston Children's Hospital. To reach Boston Children's Financial Counselors call 617-355-7201.

THE AFFORDABLE CARE ACT OF 2012 has made big changes to our health care system, including requirements for individuals, insurers and states. This had made health insurance more available and potentially more affordable; these changes are being phased in years. This website can help you keep track of new changes and how they may affect you. See healthcare.gov

WHAT IS A HEALTH INSURANCE EXCHANGE?

This is an online marketplace where you can shop for insurance plans. You can look here to see if you qualify for the government's help to cover the cost of your insurance plan. You can get information about the exchange at healthcare.gov.

WHAT IS PRIVATE/EMPLOYER-BASED HEALTH INSURANCE?

Private health insurance plans are usually offered through an employer (where you or your parents work) if you work full-time. Some employers offer only one type of health insurance plan, while others let you choose from a range of plans, like HMOs (Health Maintenance Organizations) or PPOs (Preferred Provider Organizations). The employer shares part of the cost of buying insurance. Examples of private health insurance companies are Harvard Pilgrim Health Care, Blue Cross Blue Shield and Cigna.

WHAT IS PUBLIC INSURANCE?

You might qualify for government-supported programs like Medicaid. Medicaid is a state and federal partnership health insurance program for people with low income, with or without disabilities. Medicaid waiver insurance programs cover young adults who have special needs and meet certain criteria. Learn more about Medicaid at cms.gov.

Massachusetts offers several public and private plans through MassHealth and Commonwealth Care. These can be free or very low cost. Take a look at the "What is MassHealth?" section below or mahealthconnector.org for more information.

STUDENT HEALTH PROGRAMS

College students are often required to have health insurance. Colleges and universities must offer health insurance to their student, and college students are often required to have health insurance. These health plans are called Student Health Programs (SHPs).

Students who want to enroll in a Massachusetts college or university must pay for the school's SHP plan or show that they have other health insurance that is at least as good ("comparable coverage").

Keep in mind that coverage from SHP may not be adequate and costs may be high if you have a chronic health condition or take regular medication.

Contact Student Health Services or the Office of Disability Services at your university to learn more about the health insurance that they offer.

WHERE CAN I BUY INSURANCE?

There is an open-enrollment period every year when you can buy or change plans. Unless you have a “qualifying life event,” like having a baby, marriage, or permanent move, this is generally the only time you can buy or change plans.

WHAT SHOULD I CONSIDER WHEN CHOOSING A HEALTH PLAN?

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COMPARE ALL OF THE COSTS—including:

- How much you pay in monthly premiums
- How much you pay out-of-pocket for routine health care (regular check-ups, office visits and prescriptions)
- If you get sick or injured, how much you might have to pay yourself before your insurance pays (this includes deductions, co-insurance and co-pays)

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ESTIMATE HOW MANY VISITS you will have with your primary care doctor and specialist every year to see which plan makes the most sense for you.

Rx

CONSIDER WHAT PRESCRIPTION DRUGS YOU TAKE on a regular basis. Calculate the cost to fill these prescriptions on the plans you are considering.

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INCLUDE COSTS FOR MEDICAL SUPPORTS: These could include injections, medical equipment and procedures.

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CHECK TO MAKE SURE THE DOCTORS AND SPECIALISTS you see are covered by the health insurance plan you are considereing

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ASK WHETHER YOUR EMPLOYER/INSURANCE PROVIDER OFFERS A FLEXIBLE SPENDING ACCOUNT (FSA) to further lower your costs.

USE THIS CHART
to calculate your
estimated costs AND
see which health care
plan is right for you!



COMPARE YOUR OPTIONS			
PLAN	EXAMPLE	OPTION A	OPTION B
PREMIUM (amount you pay to belong to a health plan; usually due on a monthly basis)	\$58 x 12 months = \$696		
DEDUCTIBLE (amount you pay out-of-pocket before insurance coverage kicks in)	\$500		
PRIMARY CARE VISITS (usually a family practice doctor, internist, gynecologist, or pediatrician; this doctor is your first point of contact with the healthcare system)	\$25 copayment*/visit (2 visits/year) *A copayment is a set fee you pay each time you see the doctor; your insurance plan pays the rest.		
SPECIALTY VISITS (this is a visit with a provider other than a primary care provider, or PCP; usually requires a referral from your PCP)	\$35 copayment/visit (1 visit/month)		
EMERGENCY ROOM VISITS (many insurance plans waive this fee if admitted inpatient)	\$125 copayment/visit		
INPATIENT ADMISSIONS	\$1200 copayment/inpatient stay		
PHYSICAL THERAPY/OCCUPATIONAL THERAPY/OTHER THERAPIES	\$35 copayment/visit		
PRESCRIPTIONS (medications are separated into different levels—or tiers—depending on their cost; if you are prescribed a tier 3 medication, ask your doctor if there is a less expensive equivalent)	\$10 = tier 1 (2 meds/month) \$20 = tier 2 \$30 = tier 3 Tier 1 = least expensive, generic Tier 2 = mid-range Tier 3 = most expensive		
OUT-OF-POCKET MAXIMUM (a yearly cap on out-of-pocket costs; excluding premiums)	\$2500/year		
ANNUAL LIMIT (a yearly cap on the dollar amount or types of benefits; once you’ve reached your cap, you must pay the full cost of the health care for the rest of that year)	\$1.25 million		
OTHER DETAILS (mental health coverage, vision coverage, maternity benefits, travel expenses for getting to appointments and inpatient stays, reimbursements for gym membership, weight loss programs, other programs, additional medical expenses)			
ESTIMATE OF ANNUAL EXPENSES	\$696 (premium) + \$500 (deductible) + \$50 (PCP visits) + \$420 (specialty visits) + \$840 (mental health visits) + \$240 (prescriptions) = \$2746		

GLOSSARY OF TERMS

CARVE-OUT: An arrangement in which some benefit (for example, mental health) is removed from coverage provided by an insurance plan, but are provided through a contract with a separate set of providers.

COINSURANCE: Money that an individual is required to pay for services, after a deductible has been paid. Coinsurance is often specified by a percentage. For example, the employee pays 20 percent toward the charges for a service and the employer or insurance company pays 80 percent.

COPAYS: Some plans charge copays for certain type of medical appointments. For example, \$10 for a doctor’s visit or \$75 for an emergency room visit.

DEDUCTIBLE: The amount an individual must pay for health care expenses before insurance covers the costs. Often, insurance plans are based on yearly deductible amounts.

EXCLUSIONS: Conditions or treatments and other services that a health plan will not cover. These must be clearly spelled out in materials given to you about your plan.

FLEXIBLE SPENDING ACCOUNT (FSA): Account you set up through your employer to pay for most medical expenses not covered by your insurance. Your employer automatically deducts pre-tax dollars from your paycheck so you save money. However, if you do not use all the money at the end of the year, you lose it.

HEALTH SAVINGS ACCOUNT (HSA): Similar to a flexible spending account, except that if you do not use all the money at the end of the year it rolls over to the next year.

IN-NETWORK PROVIDERS: Doctors who have a contract with a health insurance plan, so you pay less out of pocket to see them.

OPEN ENROLLMENT: A set period, usually at the end of the year, when you can enroll in a group health plan or change from one plan to another. Outside of open enrollment, only certain life-changing events (marriage, birth, divorce, etc.) may permit you to join or change plans.

OUT-OF-POCKET MAXIMUM: This limits the total amount of money you pay each calendar year for health care, including co-pays and deductibles. For example, if your policy carries a \$1,000 out-of-pocket maximum and you get sick and require a lot of health care services, the most you will pay in a year is \$1,000. After that, your insurance picks up the costs.

OUT-OF-NETWORK PROVIDERS: Doctors who do not have a contract with a health insurance plan, so you may be responsible for the entire bill.

REFERRAL: This is a written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don’t get a referral first, your plan may not pay for the services.