Your guide to

HEALTH INSURANCE

This guide has helpful information on how **health insurance helps with treatment costs.**

teva

Health Insurance and You

Health insurance is designed to help you manage your healthcare expenses. This guide provides practical information about how health insurance can help you pay for healthcare services and prescription drugs. Remember, there are variations in the ways that health insurance plans manage benefits and there may be differences in the benefits available based on the plan you choose.

Use this guide to help

- better understand what your insurance covers
- learn what you will pay for healthcare services and treatments
- compare types of health insurance plans
- find resources to help you pay for prescription drugs

What's Inside

What you need to know about health insurance

Health insurance is important for everyone

Health insurance can help you pay for medical expenses if you are sick or injured. You can also use health insurance for regular check-ups and preventive screenings.

Understanding the basics of how a health insurance plan works and learning the terms can be beneficial. Learning about health insurance allows you to ask better questions, make better insurance decisions, and get the most from your health insurance plan.

What services will health insurance cover?

Depending on your plan, health insurance might cover or help to cover:

- Preventive care, such as check-ups, screening tests, and vaccines
- Hospital outpatient care
- Laboratory tests, X-rays, and imaging
- Hospital stays
- Prescription medicines
- Mental and behavioral health treatment
- Medical equipment, such as wheelchairs
- Emergency and urgent care services
- Physical therapy and rehabilitation services
- Maternity care
- Home healthcare
- Hospice care
- Wellness programs

When choosing a health plan, or changing to a different plan, always assess the health needs of yourself and your family. Most plans will cover basic services, such as check-ups and vaccinations, but coverage of services can vary widely.

What are the different ways to get health insurance?

There are many ways to get health insurance. Here are a few examples:

Some people can get health insurance through a **group health plan**, offered by their employer or their spouse's **employer**. In most cases, the employee and employer share the monthly cost of the policy (the premium).

People can buy an **individual health insurance policy** on their own.

Some people can buy health insurance through the **Health Insurance Marketplace**, also known as the **health exchange**. Some of these plans are available at a reduced cost if certain requirements are met.

Some people may qualify for government-funded health insurance, such as Medicare or Medicaid, if they meet certain eligibility requirements.

Government health insurance programs

Medicaid: State-administered health insurance program for low-income families and children, pregnant women, the elderly, and people with disabilities. Medicaid is funded by a combination of **state** and **federal funds**. Each state's eligibility requirements are different. Check with your state to find out about coverage.

Medicare: A federal health insurance program for people **aged 65 and older**, some younger people with a long-term disability, and those with end-stage renal disease (kidney failure) and amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease).

Medicare coverage is accessed through combinations of its "Parts":

Original Medicare

Part A is hospital insurance.

Part B typically covers medications that are given at a doctor's office by a doctor or nurse. Part B covers medications like infusions, injections, or drugs that you wouldn't usually give to yourself.

Optional coverage

Part C is called Medicare Advantage. Medicare Advantage plans are privately administered, include Parts A and B, and most have prescription drug coverage.

Part D is prescription drug coverage.

Medicare supplement

Medigap is supplemental insurance that can be purchased to help with costs not covered by Parts A and B. You can purchase a Medigap plan with Part D, but not with Medicare Advantage plans.

Why is it important to review your plan every year?

Once you are insured, be sure to review your plan at least once a year. Many insurance plans change coverage benefits and premium costs each year. When it's time to renew, check to make sure that your preferred healthcare providers are still in the plan network and review any changes to your costs.

Open enrollment period

- Time when you can enroll in or change your health plan
- Occurs every year

Special enrollment periods

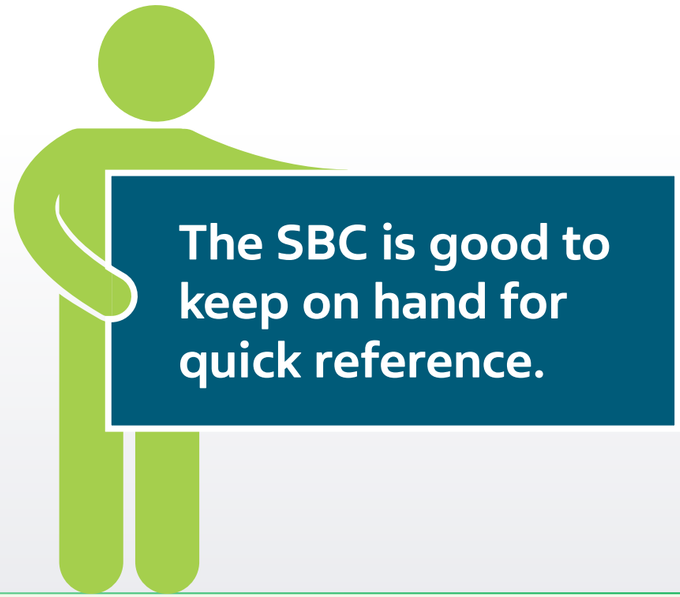
- If you have a life change, such as a job loss or marriage, you may enroll or change your health plan outside of the open enrollment period

If you have health insurance, review it every year. Your insurance needs may change over time.

Where to find out what a plan will cover

To learn more about the services covered by a plan, be sure to read the summary of benefits and coverage (SBC) for each plan you are considering.

The SBC is a short, easy-to-understand summary of what each plan covers. It can help you compare the benefits and costs of different plans.



The SBC is good to keep on hand for quick reference.

Your share of healthcare costs

Health insurance doesn't always cover 100% of your costs.
In fact, it's designed to share costs with you up until a certain point.

There are a few ways that your health insurance might share costs with you and that you need to be aware of: your copayment, your coinsurance, your deductible, and your out-of-pocket limit.

COPAYMENT

COINSURANCE

DEDUCTIBLE

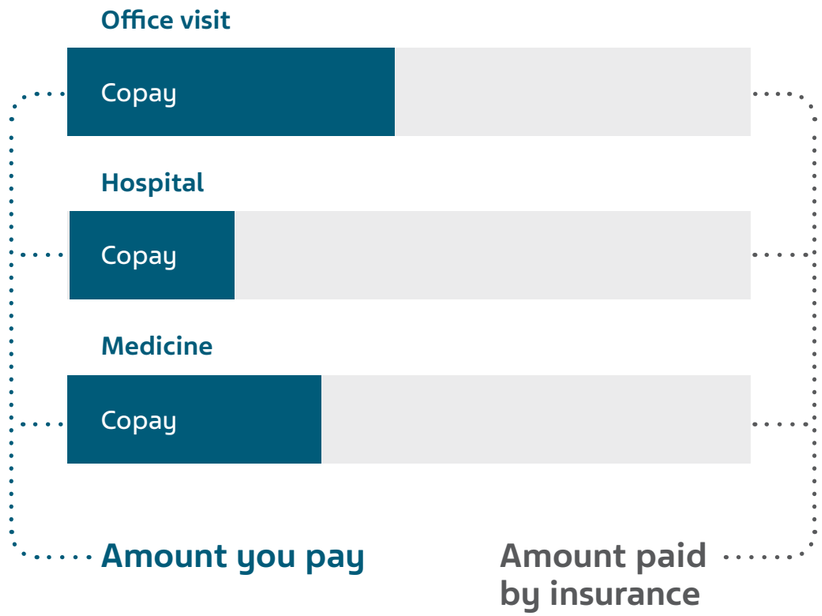
HEALTH INSURANCE

What is a copayment?

A copayment, or "copay", is a fixed amount you pay for covered medical services.

The copay amount can vary by the type of service.

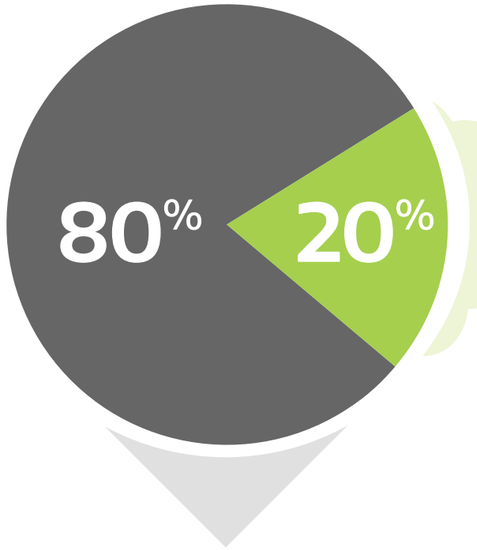
Not all services require a copay. For example, an annual check-up usually does not. You also may not have a copay on some kinds of prescriptions you take.



What is coinsurance?

Coinsurance is the percentage you pay for a covered healthcare service. You pay coinsurance after you've met your deductible.

For example, if you have already met your deductible and a hospital admission is **$10,000** and you have **20% coinsurance**, your payment would be **$2,000**. The health insurance plan pays the rest.

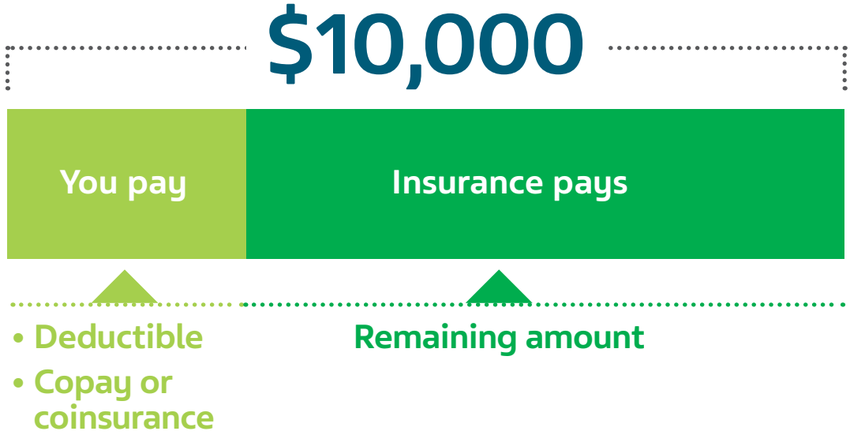


Coinsurance is the percentage of the total cost that you pay for covered services after your deductible is met.

What is a deductible?

Your deductible is the amount you pay for healthcare before your health insurance starts covering the costs.

For example, if you have a deductible of **$2,000** and a treatment that costs **$10,000**, you pay the first **$2,000** and a copayment, or some percentage coinsurance, and your health insurance pays the remaining amount.



Some expenses, like an annual check-up and health screening tests, might not be subject to the deductible, depending on your plan. Copays do not usually count toward your deductible.

Out-of-pocket limit/maximum

Your out-of-pocket limit is the **maximum dollar amount** you'll have to pay for covered healthcare services during the calendar year. Deductibles, copayments, and coinsurance payments you've made for in-network services count toward your out-of-pocket maximum. Your monthly premiums do not.

After you pay for enough medical expenses on your own to meet the maximum out-of-pocket amount, your insurance will cover 100% of your medical bills.

Monthly premiums do not count toward your out-of-pocket maximum.

How your insurance costs work when you get sick or injured

ER visit $1,000

Cost with health insurance	Cost without health insurance
$250	$1,000

Example health plan coverage

- Copay: $250
- Deductible: N/A
- Coinsurance: N/A

Patient pays:

- $250 ER copay

Hospital admission $10,000

Cost with health insurance	Cost without health insurance
$3,600	$10,000

Example health plan coverage

- Copay: N/A
- Deductible: $2,000
- Coinsurance: 20% after deductible is met

Patient pays:

- $2,000 deductible*
- $1,600 coinsurance†

*If your deductible was already met, you would pay $0 deductible and are only subject to coinsurance.
† If your your out-of-pocket limit was reached, you would pay $0 coinsurance and all costs would be covered by health insurance.

Types of healthcare plans: HDHPs

How high-deductible health plans (HDHPs) work

- These plans have a higher deductible than other insurance plans. Therefore, you pay more of your healthcare costs before the insurance starts to pay its share for services, other than in-network preventive care
- Plans may offer an accompanying Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). These accounts can help you save money on current and future healthcare expenses

What are HSAs and HRAs?

HSAs are a type of savings account that allow you to set aside money on a **pre-tax** basis to pay for qualified medical expenses. An HSA is coupled with a an HDHP. Funds may roll over year to year. HRAs are a kind of health spending account provided and owned by an employer. HRA funds may not roll over to the next calendar year, depending on the plan.

HSA funds roll over year to year if you don't spend them.

You can take the funds with you if you change jobs.

Types of healthcare plans: Private plans

Preferred Provider Organization (PPO)

- You pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost

Health Maintenance Organization (HMO)

- Your coverage may be limited to care from doctors, hospitals, and providers in your network

Point-of-Service (POS) plan

- You pay less if you use providers in the plan's network. You need a referral from your primary care physician to use doctors, hospitals, and providers outside of the network, for an additional cost

Exclusive Provider Organization (EPO)

- Your services are covered only if you use doctors, hospitals, and providers in the plan's network (except in an emergency)

When choosing a plan, consider the premiums, deductibles, and your and your family's healthcare needs for the current year. Changing circumstances may require a change in plan type.

How plans help pay for your prescription drugs: Private plan

Your pharmacy benefit may help pay for your medication if obtained through a local retail pharmacy or, in some cases, what is called a specialty pharmacy. Your pharmacy benefit may cover medications such as:

- pills
- injections that you can give yourself, such as those given under the skin

Your medical benefit may help pay for medications given by a healthcare professional, such as a doctor or nurse. Medications that you generally cannot administer yourself include:

- infusions
- some kinds of injections

Your out-of-pocket costs for prescription drugs may depend on the formulation of the medication. If your prescription drug costs are too high, check with your doctor and the office administrator about alternative treatment formulations. There may be options.

How plans help pay for your prescription drugs: Medicare plan

If you have Medicare, your medication may be covered under Part B or Part D.

Part B: Typically covers medications given by a healthcare professional, such as a doctor or nurse.

Part D or Medicare Advantage Prescription Drug Plan: May cover your medication if obtained through a pharmacy or, in some cases, a specialty pharmacy.

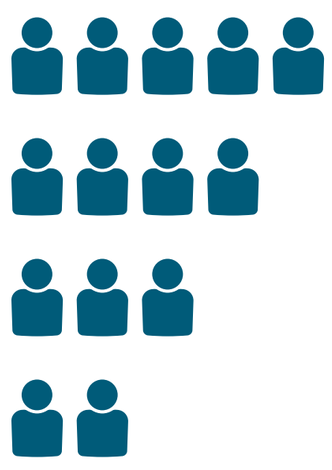
Part D plans have 4 distinct phases, each with specific out-of-pocket costs that accumulate over the course of the calendar year. Once you have paid the maximum amount in each phase, you move into the next phase.

Deductible: You pay 100% of **retail** drug cost up to initial **deductible**

Initial coverage: You pay 25% of **retail** drug cost before meeting the coverage limit

Coverage gap: You pay 25% of **generic or brand-name retail** drug price up to the catastrophic limit

Catastrophic coverage: You pay no more than 5% of drug costs



Not everyone with Part D coverage advances through all phases. Your prescription needs and individual policy determine your actual out-of-pocket costs.

Understanding formularies

Every health plan has its own formulary. A formulary is a list of drugs covered by the plan.

Formularies often have different levels or tiers of coverage for different drugs. The higher the tier, the more a drug will cost you. Sometimes, some brand-name drugs are labeled "preferred" and others used to treat the same condition are labeled "non-preferred." Preferred drugs are generally less expensive.

Tier 1
Generic Drugs
$

Tier 2/3
Brand-Name Drugs
$$

Tier 4/5
Specialty Drugs
$$$

You may have to pay a higher cost or the full cost of the drug for medications that are not included in your health plan's formulary.

Provider Networks

Some insurance plans pay for medical care only when the provider who treats you is part of the network plan.

Providers who are part of a plan are called preferred providers

Providers who are not part of a plan are called non-preferred providers

Depending on the plan, you may have to pay some or all of the costs yourself if you choose to visit a non-preferred provider. To learn more about a plan's in-network and out-of-network coverage, be sure to review the SBC for the plan.

When choosing a new plan, or renewing your existing plan, review the SBC to see if your healthcare providers are part of the network.

What if your health insurer denies coverage of your treatment?

First, talk to your doctor or someone at his or her office.

Most providers have an office manager who can help you.

Questions you could ask:

- Is there a different medication I can take? One that works the same way, but that my health insurer will help pay for?
- How do I appeal the denial? Can you help me with an appeal?
- The denial notice says the medication needs to be "medically necessary"? What should I do?

Second, contact your health insurance company.

If you've received a denial and want to appeal, you can prepare for your conversation by gathering your documents:

Insurance cards

The denial letter

Questions you could ask:

- How do I appeal the denial?
- If my appeal is also denied and we have a dispute, how is a dispute resolved?
- Are there important deadlines that I need to meet?

What you can do if you cannot afford a prescription

There are resources that can help you get assistance with paying for medications. Teva Pharmaceuticals may be able to help.

Teva offers **Comprehensive Oncology Reimbursement Expertise (CORE)** to patients, their caregivers, and healthcare professionals. CORE offers assistance and resources to help patients better understand reimbursement eligibility. Visit **tevacore.com** or call **1-888-587-3263** to learn more.

The **Teva Cares Foundation** is a group of patient-assistance programs created to make a positive difference in the lives of patients, families, and local communities. Teva's commitment to patients provides certain Teva medications at no cost to patients in the United States who meet certain insurance and income criteria.

Visit **tevacares.org** or call **1-877-237-4881** to learn more about eligibility and program details.

Where you can find answers to questions about your health insurance

You can get answers about your benefits through your insurance company in several ways:

- **Call your insurance company member services** (and ask to speak to a supervisor, if necessary)
- **Ask questions through member services portals** (which gets your information in writing)
- **Talk to your doctor's office administrator**
- **Call your trusted insurance agent**

Additional resources
Health Insurance Marketplace
www.HealthCare.gov, 1-888-318-2596

Medicare and Medicaid
1-877-267-2323
www.cms.gov

Health Insurance Terms

Coinsurance: The amount you must pay for medical care after you have met your deductible. Typically, your plan will pay 80% of an approved amount, and your coinsurance will be 20%, but this may vary among health insurers.

Coordination of benefits: Claims must be coordinated to determine which plan pays first when you have coverage through more than 1 insurance plan.

Copay (or copayment): The flat fee you pay each time you receive medical care. For example, you may pay $30 each time you visit the doctor. Your plan pays the rest.

Deductible: The amount you must pay each year before your plan begins paying covered healthcare costs.

Exclusive Provider Organization (EPO): A form of managed care where services are covered only if you go to doctors, hospitals, and providers in the plan's network (except in an emergency).

Formulary: A list of drugs that your insurance plan will cover. It may include the amount you would pay for each drug.

Health insurance marketplace (or health insurance exchange): A marketplace where consumers can purchase insurance. Some states have state-specific exchanges.

Health Maintenance Organization (HMO): A form of managed care in which you receive all of your care from participating providers.

Health Reimbursement Arrangements (HRA): A kind of health spending account provided and owned by an employer. HRA funds may not roll over to the next calendar year, depending on the plan.

Health Savings Account (HSA): A type of savings account that allows you to set aside money on a pre-tax basis to pay for qualified medical expenses. An HSA is coupled with a "high-deductible" health insurance plan.

High-Deductible Health Plan (HDHP): An element of managed care plans that have a higher deductible than other insurance plans. Therefore, you pay more of your healthcare costs before the insurance starts to pay its share, other than in-network preventive care.

Individual/family plan: Coverage purchased independently (not obtained from a job or as part of a group).

Medicaid: State-administered health insurance program for low income families and children, pregnant women, the elderly, and people with disabilities. Medicaid is funded by a combination of state and federal funds. Each state's eligibility requirements are different.

Medicare: A federal insurance program that provides healthcare coverage to individuals aged 65 and older, some younger disabled people, and those with end-stage renal disease (kidney failure).

Out-of-pocket costs: Health or prescription drug costs that you must pay on your own because they are not covered by insurance.

Point-of-Service (POS) plan: A form of managed care in which primary care physicians coordinate patient care, but there is more flexibility in choosing doctors and hospitals than in an HMO.

Preferred Provider Organization (PPO): A form of managed care in which you have more flexibility in choosing doctors and other providers than in an HMO. You can see both participating and non-participating providers, but your out-of-pocket expenses will be lower if you see only in-network providers.

Premium: The amount you pay each month to belong to a health insurance plan.

Summary of Benefits and Coverage (SBC): A short, easy-to understand summary of what each plan covers. It can help you compare the benefits and costs of different plans.

Notes

My health plan type:

My copay amount:

My coinsurance amount:

My out-of-pocket maximum:

My annual deductible:

My monthly premium:

My primary care provider contact information:

My specialist(s) contact information:

My medications:

At Teva, our mission and values guide us to ensure that you—our patients, our customers, our colleagues, and our communities—are at the heart of every decision we make.

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