Your guide to

HEALTH INSURANCE BASICS

A guide that provides you a **basic overview of health insurance** and explains how it can help with your healthcare 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 you:

- ✓ Better understand what your insurance covers
- ✓ Learn what you will pay for healthcare services and treatments
- ✓ Find answers to questions about your health insurance

What's inside

Health insurance overview

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 checkups 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 partially cover:

- Preventive care, such as checkups, screening tests, and vaccines
- Sick visits
- 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 health care
- Hospice care
- Wellness programs

How health insurance works

Health insurance plans usually include 2 separate types of benefits:

Medical benefits

Your medical benefits help pay for care you receive in a hospital and outpatient care, such as doctor visits, laboratory tests, and medications administered in the doctor's office.

Pharmacy benefits

Your pharmacy benefits help pay for the cost of prescription drugs that you can administer to yourself without a healthcare provider.

What are the different ways to get health insurance?

There are many ways to get health insurance

People can get health insurance through a **group health plan** offered by their **employer** or their spouse's employer. In most cases, the employee pays for part of the monthly cost of the policy (the premium).

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

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

Some people, if they meet certain requirements, may qualify for government-funded health insurance.

Government health insurance programs

Medicaid: A joint state and federal program for low-income families and children, pregnant women, and some people with disabilities; programs vary from state to state.

Medicare: A federal program for people aged 65 and older, some younger people with a long-term disability, and some others with specific diagnoses.

Children's Health Insurance Program (CHIP): A joint state and federal program for children of families who don't qualify for Medicaid; programs vary from state to state.

Veterans Health Administration (VA): A federal program for eligible veterans.

Tricare: A federal program for military service members, retirees, and their families.

Indian Health Service (IHS): A federal program that provides health services to American Indians and Alaska Natives.

Medicare coverage is accessed in 2 main ways

Original Medicare

Part A is hospital insurance.
Part B is medical insurance.

You can add:

Medigap is supplemental coverage that helps pay for some of the costs not covered by Part A and Part B.

OR

Medicare Advantage

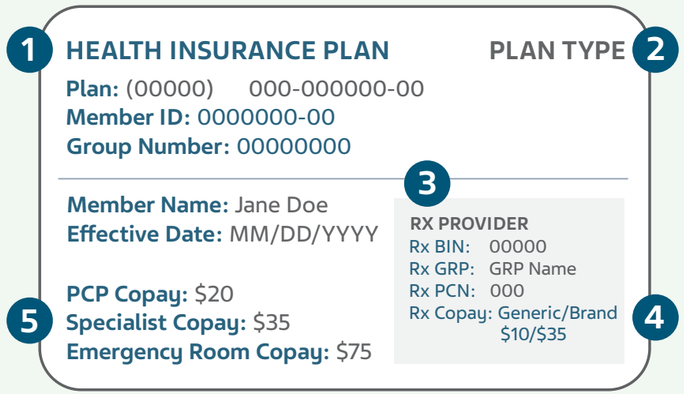
Medicare Advantage is also called **Part C**, and it includes Part A, Part B, and usually Part D; plans are offered by private companies.

If not included, you can add:

Part D is prescription drug coverage; plans are offered by private companies.

How do you read your insurance card?

Take out all the insurance cards you use when you visit a doctor, go for a lab test, or pick up a prescription. Insurance cards can look different but generally include the same type of information.



1. This is where you can find the **name of the insurance company** that administers your insurance plan.
2. This is where you can find additional **information about your specific type** of health insurance plan.
3. This is your **pharmacy benefits manager (PBM)**—the organization that provides your pharmacy coverage. You may have a separate insurance card for your pharmacy benefit.
4. This is your **prescription drug (Rx) copay**—the amount you'll pay per prescription for different types of medications. This copay may not include specialty medications or drugs that are paid under the medical benefit.
5. This shows your **covered service copay**—the amount you will pay out of pocket for a visit to your primary care physician (PCP), specialist, or emergency room.

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 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 getting married, having a baby, or have lost your health insurance coverage, you may enroll in or change your health plan outside of the open enrollment period

Changes in government policies and laws are more good reasons to review your health plan every year. These types of updates can affect coverage benefits and how much you pay out of pocket for your health care coverage and medications.

Your healthcare costs

Health insurance doesn't always cover 100% of your costs

In fact, it's designed to share costs with you up to a certain point.

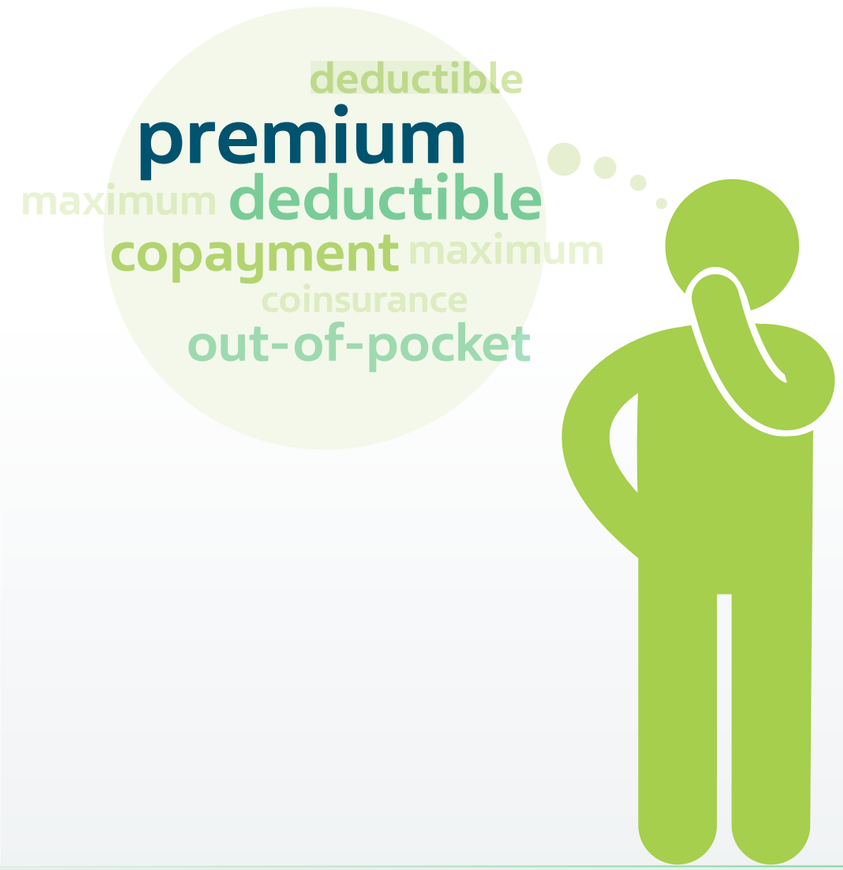
There are a few ways that your health insurance might share costs with you that you need to understand.

What is a premium?

Insurance premiums typically change every year

The **premium**, just like your car or house insurance, is the amount you pay monthly for the insurance. In some cases, the premium expense is shared, like when your employer pays part and you pay the other part.

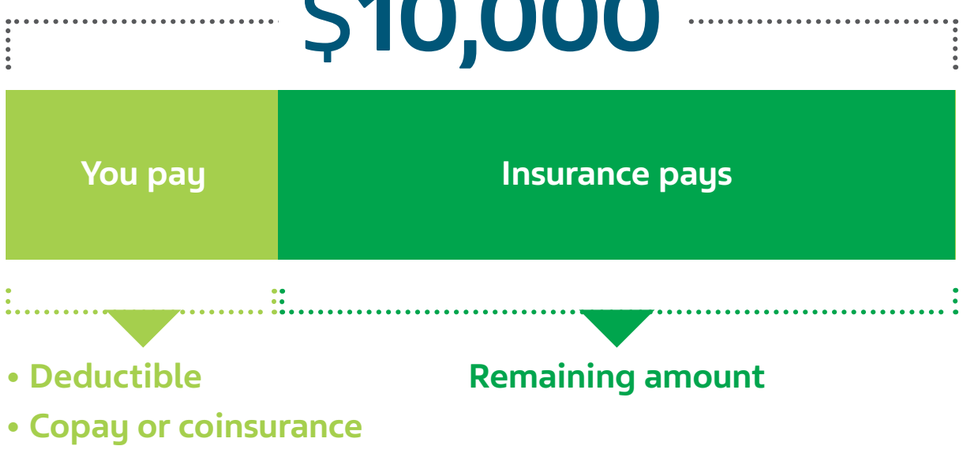
Insurance premiums do not count toward your deductible or your out-of-pocket maximum.



What is a deductible?

Your **deductible** is the amount you pay for health care 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.



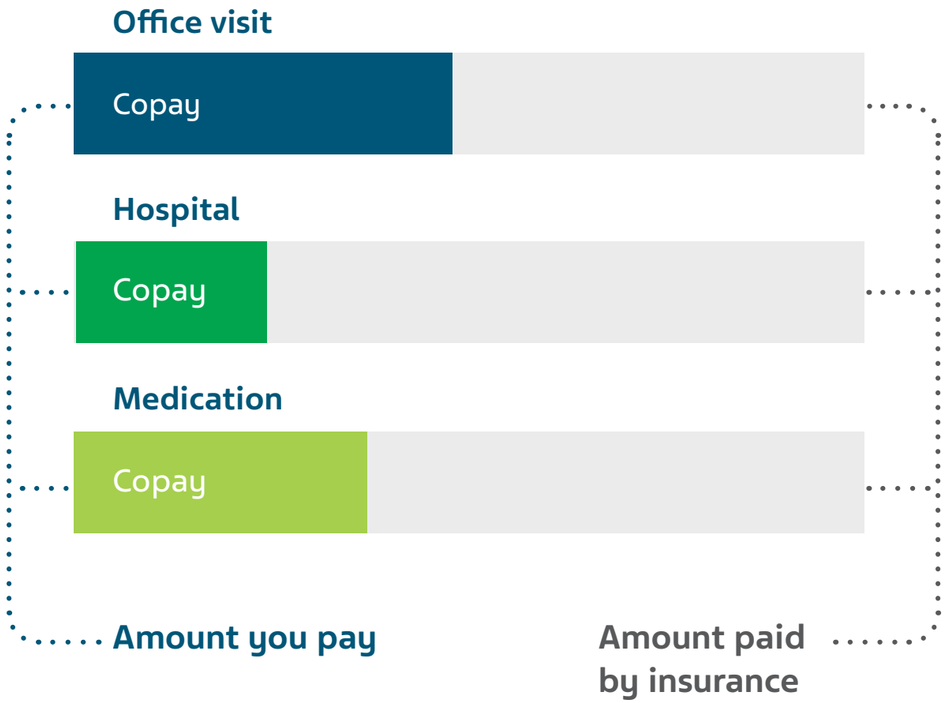
Some plans lower their premiums by charging a higher deductible. If the annual deductible is more than $1,650 for individual coverage, or $3,300 for family coverage, this would be referred to as a high-deductible health plan (HDHP).

What is a copayment?

The copay amount can vary by the type of service

A copayment, or "**copay**," is a fixed amount you pay for covered medical services. For example, you may have a **$50** copay for a visit to a specialist.

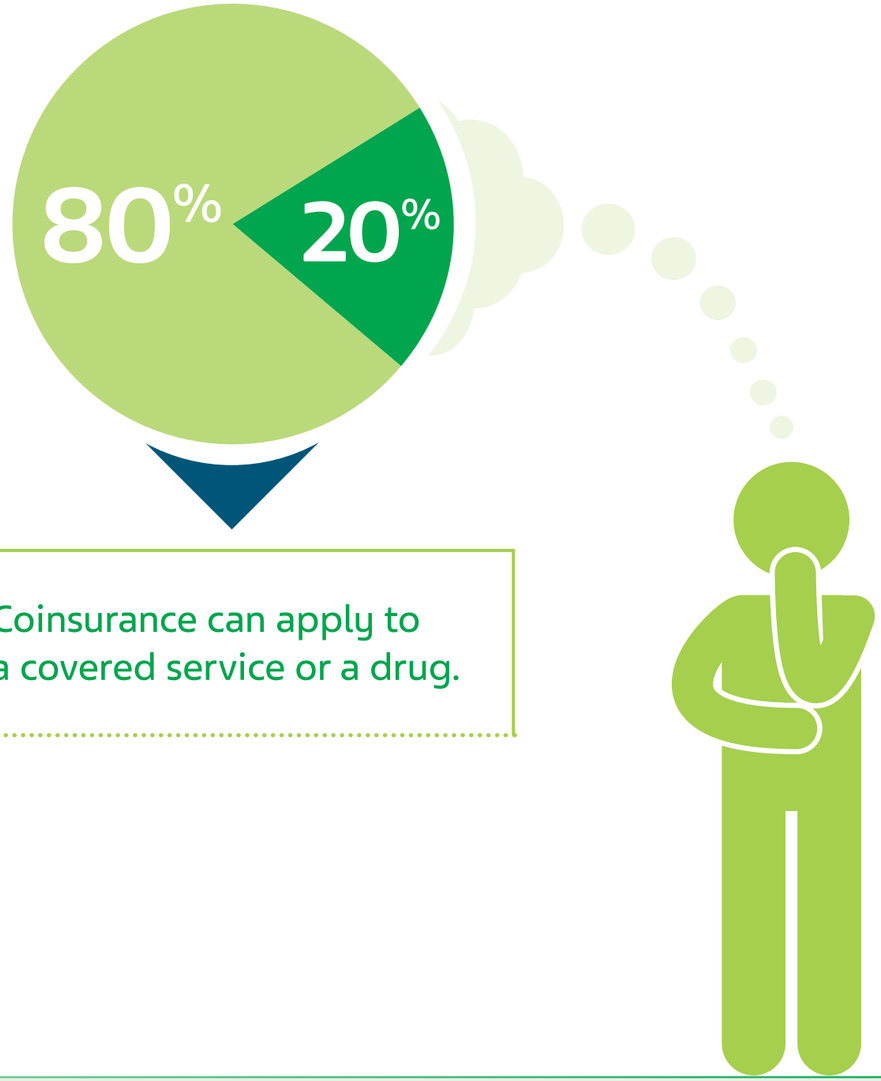
Not all services require a copay. For example, an annual checkup usually does not. You also may not have a copay for some kinds of prescriptions you take.



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 costs **$10,000** and you are required to pay **20% coinsurance**, your payment would be **$2,000**. The health insurance plan pays the rest.



Coinsurance can apply to a covered service or a drug.

What does out-of-pocket limit mean?

Your out-of-pocket limit is the maximum dollar amount you'll have to pay for covered healthcare services during the calendar or plan 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.

While the out-of-pocket limit for Health Insurance Marketplace® plans can vary, it can't go over set amounts each year for an individual and for a family.

DEDUCTIBLE
+
COPAYMENTS
+
COINSURANCE
▼
OUT-OF-POCKET MAXIMUM

How does insurance cost sharing work?

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

You pay:

- $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

You pay:

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

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

Types of health insurance plans

There are different types of plans designed to meet your needs

Some plans restrict your out-of-network provider choices more than others. You will typically pay more to see out-of-network providers.

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 managed care plans?

Whether you have private health insurance or a government plan through Medicare or Medicaid, your insurance may be a "**managed care**" plan. Managed care is a type of health care that focuses on helping to **reduce costs**, while delivering a **high quality of care**. There are several common types of managed care plans.

Most restrictive

Lowest cost

Least restrictive

Highest 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 PCP to use doctors, hospitals, and providers outside of the network, for an additional cost

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

Out-of-pocket costs, choice of providers, and access to care in different parts of the country are some important considerations when choosing your plan.

What are provider networks?

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

Providers who are part of a network are called preferred providers

Providers who are not part of a network 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 your plan documents.

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

Prescription drug coverage

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

- Pills
- Inhaled medications
- Injections that you can give yourself

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

Pharmacy benefit

If you give yourself the medicine, it is probably covered under the pharmacy benefit.

Medical benefit

If a healthcare provider has to administer the medicine, it is probably covered under the medical benefit.

What is a formulary?

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 you will pay out of pocket. Sometimes, some brand-name drugs are labeled "preferred" and others used to treat the same condition are labeled "non-preferred." Preferred drugs generally have a lower out-of-pocket cost.

Tier 1 Generic drugs	$
Tier 2/3 Brand-name drugs	$$
Tier 4/5 Specialty drugs	$$$

Many drug plans have preferred and non-preferred pharmacies in their network. You may pay less for your drugs at preferred pharmacies.

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.

How does Medicare help?

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

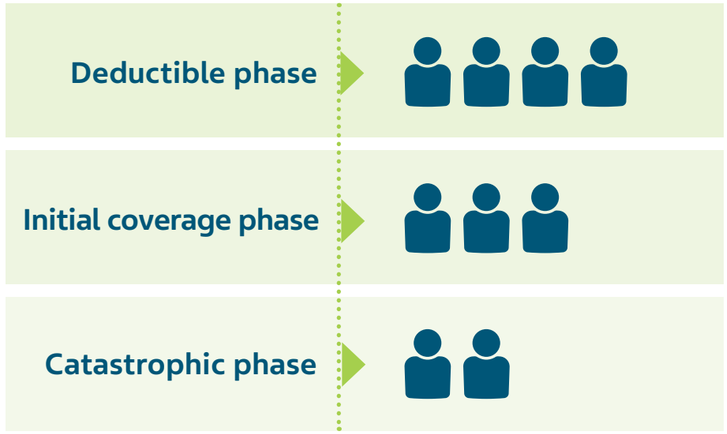
Part B: Typically covers medications given by a healthcare professional, such as a doctor or nurse.

Part D: May cover your medication if obtained through a retail pharmacy or, in some cases, a specialty pharmacy.

Part D plans have 3 phases, each with specific out-of-pocket costs that accumulate over the course of the calendar or plan year. Once you have paid the maximum amount in each phase, you move into the next phase.

Phases

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



- Out-of-pocket costs, including the deductible, copayments, and coinsurance, are capped at $2,000 in 2025
- To help manage out-of-pocket prescription drug costs, Part D enrollees can spread the cost across the calendar year by enrolling in the **Medicare Prescription Payment Plan**

Coverage denials

Steps to take when coverage is denied

1 **Talk to your doctor or someone at the office.**
Most providers have an office manager who can help you.

Questions you could ask if your plan denies coverage for your prescription medication:

- Is there a different medication I can take? One that works the same way, but that my plan will pay for?
- What should I do if the denial says my medication needs to be "medically necessary"?
- How can this denial be appealed? Can you help?

2 **Contact your health plan.**
If you've received a denial and want to appeal, you can prepare for a conversation by gathering your documents:

- Insurance cards
- Denial letter

Resources

Children's Health Insurance Program (CHIP)

Access your individual state's Medicaid and CHIP website at **www.insurekidsnow.gov**.

Medicaid

Access the official Medicaid site at **www.medicaid.gov** to find links for every state's individual Medicaid website to learn about eligibility and coverage and to explore their resources.

Medicare

You can find many helpful resources at **www.medicare.gov/publications**, including the following publications:

Medicare & You Handbook
The official government Medicare handbook that includes a summary of Medicare benefits, rights, and protections; lists available health and drug plans; and answers frequently asked questions about Medicare.

Your Guide to Medicare Prescription Drug Coverage
Explains how your coverage works, how to get Extra Help if you have limited income and resources, and how Medicare drug coverage works with other prescription drug coverage you may have.

Medicare & Other Health Benefits: Your Guide to Who Pays First
Explains how Medicare works with other types of coverage, who should pay your bills first, and where to get help.

Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare
Provides information on choosing a Medigap policy to supplement the Original Medicare plan.

Veterans Health Administration (VA)

Visit the official US Department of Veterans Affairs website at **www.va.gov** for eligibility and enrollment information.

Tricare

Learn all about the US military's healthcare program by visiting **www.tricare.mil**.

Other resources

Health Insurance Marketplace

Explore coverage options and connect with a local insurance agent/broker.

Visit **www.healthcare.gov** or call **1-888-318-2596** to learn more.

State Health Insurance Assistance Program (SHIP)

Provides local, in-depth, and objective insurance counseling and assistance to Medicare-eligible individuals, their families, and caregivers.

Visit **www.shiphelp.org** or call **1-877-839-2675**.

Centers for Medicare and Medicaid Services (CMS)

The federal agency that is responsible for Medicare, Medicaid, state Children's Health Insurance Programs, and the Health Insurance Marketplace.

Visit **www.cms.gov** or call **1-877-267-2323** to explore their resources.

Other ways to get the help you need

If you have health insurance, contact customer or member services
- Find the phone number on the back of your insurance card, or
- Use the chat function on your online member portal (this gets your information in writing)

Talk to your doctor's office and ask if there is a staff member who can help you

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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