Private Health Plan Comparison Guide

Determining which health plan is most appropriate for your needs can often be a difficult process whether it is an individual or family policy offered through your employer (a group health plan) or one you acquired as an individual. There are many things to consider when reviewing your options. These considerations fall under two categories: cost and benefit design. Most people first consider the cost of a plan when making a decision. Our goal is to provide you with a tool to help you compare and evaluate the cost and benefits of various plans that may be offered to you by an employer or an insurance Marketplace in your state. Questions typically asked by people when choosing a plan include:

- What is the monthly/annual premium for the plan?
- What is the total of my yearly out-of-pocket costs, including medical and prescription co-pays, deductibles and coinsurance?
- Does it cover all the services I need?
- Are my physicians in network?
- Are there annual limits on the number of visits for any particular service? (For example, physical therapy is often limited to a certain number of visits per year.)
- Are out-of-network benefits available? What percentage of the cost am I responsible for if I receive out-of-network care?
- Am I covered if I get sick/need treatment out of state?

For those affected by primary immunodeficiency disease, there are often additional, more specific questions you must ask that relate to what benefits are covered and how, such as:

- Is immunoglobulin (Ig) therapy covered? If so, is it a part of major medical or a pharmacy benefit?
- Do I have a choice of site of care (hospital, home infusion, physician’s office)?
- Do I have a choice of administration of therapy, i.e. subcutaneous (SCIG) or intravenous (IVIG)?
- What is my out-of-pocket cost for my Ig therapy?
- Are supplies and nursing services covered?
- Do I need a referral to see a specialist?
- What services require prior authorization?
- Is Ig therapy subject to a restrictive formulary?
- Will I be required to switch from my current Ig product to another product?
- Does the plan provide a case manager to assist me with navigating my benefits?

Answers to some of these questions, relative to cost and generally covered benefits, can be found by reviewing a plan’s summary of benefits, drug formulary list and provider network directory. However, sometimes you will need to find out more information from the plan to get all of the information you need. While this is often considered a tedious process, it is one of the most important steps you can take to ensure that a plan meets your needs. It is better to know everything you can about your plan before you pick it than finding out problems and hidden costs after you have made a decision.

It is important to remember that... **Once you choose a plan, you cannot change until the next open enrollment period** unless you experience a qualifying life event.