Health Coverage Options Guide

Overview

At Fresenius Kidney Care, we know that providing superior patient care goes beyond delivering industry-leading dialysis services. We also strive to help patients like you navigate non-clinical aspects of their care. This includes helping patients understand the healthcare insurance options available to them. Fresenius Kidney Care insurance coordinators are available to help you identify the coverage options that best suit your individual circumstances. Our insurance coordinators can explain your options and help you understand the many individual factors involved. The choice of coverage is up to you.

Your healthcare coverage options fall into two broad categories: private commercial coverage and government-sponsored coverage.

Commercial coverage

Private commercial coverage can include coverage through an employer or through a health plan purchased on or off the Affordable Care Act Health Insurance Exchange Marketplace (sometimes called “Obamacare”).

Coverage through an employer

You may be entitled to coverage under an **Employer Group Health Plan** (EGHP) if you or a spouse or partner (or if under 26, a parent) is a current employee of an employer that offers an EGHP. Premiums are typically paid through a combination of employer contributions and employee payroll deductions. Premium and out-of-pocket costs (including deductibles and co-payments) as well as the range of covered health benefits can vary widely among EGHPs. Your insurance coordinator can help you understand your EGHP coverage so that you can determine whether coverage through your employer best suits your circumstances.

Even if you are no longer eligible for coverage under an EGHP, it may be possible to extend your EGHP coverage through what is known as **COBRA continuation coverage**. COBRA can provide coverage for up to 18 months (or in some circumstances up to 36 months), depending on why you lost your EGHP coverage and other factors. If you experience a "qualifying event," for example, because you have been terminated from your employment or have had your hours reduced, you will be given an election period of at least 60 days to elect COBRA continuation coverage. Your coverage is then retroactive to the date of the qualifying event. If you elect COBRA continuation coverage, you may be responsible for up to the full premium cost, including the share that both you and your employer previously paid. You also may be required to pay an administrative fee of not more than 2% of the full premium amount.

Some states offer "mini-COBRA" programs that may allow you or your family members to maintain EGHP coverage if you don't qualify for regular COBRA coverage. If your employer has fewer than 20 employees, for example, a state mini-COBRA plan may be your only option to continue your coverage under an EGHP. Your insurance coordinator can help determine which options are available to you.

In-network and out-of-network providers

Some insurance plans rely on networks of providers, so it is important to determine whether your dialysis facility and other healthcare providers are considered "in-network" or "out-of-network." Being in-network means your provider has agreed to participate in the plan's contracted network of providers, typically in exchange for the provider's agreement to accept discounted rates for their services. If you visit an out-of-network provider, your co-payments likely will be higher and you may be required to pay the difference between what the insurer pays and the provider's undiscounted rates.

Coverage through the Affordable Care Act exchange

You may also choose to purchase private commercial insurance through the Affordable Care Act Health Insurance Exchange. These types of plans are called **Qualified Health Plans** (QHPs) because they provide at least the minimum essential benefits required under the Affordable Care Act. These plans are sometimes referred to as "Obamacare" plans. Some QHPs provide coverage both for you and your family. You may be eligible for certain tax credits to help you pay QHP

premiums. You can find a description of each QHP available in your state, including the type of coverage you would receive and your premium and out-of-pocket costs, at www.Healthcare.gov. Your insurance coordinator can help you review QHP options with you.

If you are employed by a small business, your employer may have used another type of marketplace created by the Affordable Care Act, called the Small Business Health Options Program Marketplace (SHOP), to purchase a health plan for its employees. These plans offer the same types of essential health benefits as QHPs, but may have different types of coverage and costs depending on the type of SHOP plan your employer has selected.

Coverage off the Affordable Care Act exchange

You can also obtain private commercial coverage "off" the Affordable Care Act Exchange if you purchase a plan directly from an insurance company or through an insurance agent outside of the Exchange. Even off-Exchange plans must meet certain requirements under the Affordable Care Act. For example, an insurance company cannot refuse to cover you or charge you more because you have a pre-existing condition. However, these off-Exchange plans do not have to offer the same level of coverage that QHPs are required to provide. Be aware that if you buy a plan off the exchange that does not offer the same level of coverage as a QHP, you may have to pay a penalty that could be taken directly from your current or future federal income tax refund or added to the amount of federal taxes you owe the government.

Government-sponsored coverage

Government-sponsored coverage can include Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and certain health benefits for military personnel and their families. Your insurance coordinator can help review what options may be available to you

Medicare

Medicare is health insurance for people who are 65 and older, or who are under 65 with certain disabilities. In addition, Medicare can provide coverage for people of any age with End Stage Renal Disease (ESRD), which is permanent kidney failure that requires dialysis or a kidney transplant. For United States citizens with ESRD, you can apply for Medicare if you have sufficient work credits, if you are already getting or are eligible for Social Security or Railroad Retirement Board benefits, or if you are a spouse or dependent child of a person who meets either of these two requirements.

Medicare coverage, part A to D

Medicare coverage is divided into four "parts," called Medicare Parts A, B, C and D. Medicare Part A covers hospital care, certain nursing home care and certain home health services. Medicare Part B covers outpatient care, such as dialysis services and doctor visits, and a variety of other related services such as laboratory tests, diagnostic tests (like x-rays), and certain medical equipment and supplies. It is your choice whether to enroll in Medicare, and which parts you select.

If you have Medicare Part A and B, you can go to any healthcare provider that accepts Medicare. Medicare sets the rates that providers can charge. You will pay 20% co-insurance for all covered dialysis-related services and most other healthcare services under traditional Medicare. Medicare pays the other 80%. Most Medicare beneficiaries do not have to pay a monthly premium for Part A, but most do have to pay a monthly premium for Part B. You must also pay a deductible before Medicare begins to pay its share.

If you receive a kidney transplant, you will pay a deductible and certain co-insurance amounts based on the number of days you have to stay in a hospital or skilled nursing facility. Medicare pays the full cost of care for your kidney donor.

Applying for Medicare if you have ESRD

If you are eligible to enroll in Medicare because you have ESRD and you are currently on dialysis, you can apply for Medicare coverage through your Social Security office. Additional information is available at www.ssa.gov/benefits/medicare, or you can ask your insurance coordinator for assistance. Medicare coverage usually starts on the 1st day of the 4th month of your dialysis treatments, so it is important to apply as soon as you begin dialysis if you want Medicare benefits to begin as soon as possible. In some circumstances, your coverage can start as early as the 1st month of dialysis, for example, if you take part in a home dialysis training program to teach you how to give yourself dialysis treatments at home. If you are getting a kidney transplant, your Medicare coverage can begin the month you are admitted to a hospital for a kidney transplant (or for healthcare services you need before the transplant). If your transplant is delayed more than 2 months after you are admitted for the transplant or for services you need before your transplant, your coverage can start 2 months before you have your transplant.

When Medicare coverage ends

If you are enrolled in Medicare because of ESRD, and cease dialysis treatments because you received a successful transplant, Medicare coverage will continue for a 36-month period beginning the month after the transplant. If you have another transplant during a 36-month post-transplant period, Medicare coverage continues for 36 months after the month of that transplant. If you resume dialysis during a 36-month post-transplant period, Medicare coverage will continue. If you resume dialysis after that period, you will be eligible to re-enroll in Medicare starting the first month after you resume dialysis.

If you are enrolled in Medicare because of ESRD, and cease dialysis treatments other than because you received a successful transplant (for example, if you regain kidney function), Medicare coverage will end 12 months after the month you stop dialysis treatment. Medicare coverage will continue, however, if you resume dialysis treatments, or will be extended for 36 months (as discussed above) if you have a successful transplant during that 12-month period. If you resume dialysis after that 12-month period, you will be eligible to re-enroll in Medicare starting the first month after you resume dialysis.

Coordination of benefits

There is usually a waiting period for your Medicare coverage to start once you begin receiving dialysis treatments. During this time, if you have other private commercial insurance, that plan will pay for your first 3 months of dialysis. Even after your Medicare coverage begins, if you maintain coverage under a group health plan, it will continue to pay covered healthcare costs. Your group health plan will pay first during this "coordination period," which lasts for 30 months. If your plan does not cover 100% of these costs during the coordination period, you generally will not be responsible for any additional costs if you have "secondary" coverage under Medicare. If you have commercial plan coverage that pays for most or all of your healthcare costs and that you wish to keep, you may want to consider delaying Medicare enrollment until after the coordination period so you won't have to pay Medicare Part B premiums.

After the coordination period, Medicare will pay first for all covered healthcare services, and your commercial plan will pay the portion Medicare does not pay (plan deductibles and coinsurance may apply). Please make sure to let your insurance coordinator know if you have existing private commercial insurance coverage before you apply for Medicare so that we can bill for your treatment correctly.

Medicare Advantage (Medicare Part C)

Medicare Advantage is a health insurance that offers the same coverage as Medicare Parts A & B, along with extra benefits that may include prescription drug coverage, dental, vision, hearing, transportation, and fitness coverage. Medicare Advantage Plans, sometimes called Medicare Part C or MA Plans, are a replacement for other Medicare options.

Medicare Advantage plans are offered and managed by private health insurance companies. Out-of-pocket costs vary per plan, but typically include a monthly premium, copays and coinsurance with a cap on annual out-of-pocket costs. Medicare Advantage plans rely on provider networks, similar to coverage you would get from an employer, so it's important to check if your doctor is in-network with the plan you choose.

You can search for a Medicare Advantage plan by using the Medicare Plan Finder, available at www.Medicare.gov/Find-A-Plan.

Medicare Part D

If you are enrolled in Original Medicare, you can add prescription drug coverage by joining a Medicare Part D plan. Many of the drugs you may need for dialysis treatment, or after a kidney transplant, will be covered under Medicare Part B. However, Part B may not cover other prescription drugs you may be prescribed, such as drugs for high blood pressure. Many Medicare Part D plans require you to pay an initial deductible and some cost-sharing for your prescription drug benefit. Your cost-sharing will vary based on your plan and the types of drugs you are prescribed. If your total drug costs reach a certain amount, then you enter into a "coverage gap" or "donut hole" where you must pay a percentage of the total cost of your medications. However, under a standard Part D plan, once you reach a point beyond the donut hole, called "catastrophic coverage," you will pay a set price or small percentage, whichever is greater.

Medicare Part D can be selected with Medicare Parts A and/or B or a Medigap plan without prescription coverage, but cannot be selected with Medicare Part C (Medicare Advantage) or Medigap plans with prescription coverage.

Please note that all cost-sharing amounts for your prescription drug benefit may be less based on your income. You can search for a Medicare Part D plan in your area by using the Medicare Plan Finder, available at www.Medicare.gov/Find-A-Plan.

Medicare Supplement Insurance (Medigap)

Medicare Supplement Insurance, or Medigap, is sold by private commercial insurers to help individuals pay for healthcare costs that are not covered by Original Medicare, including deductibles, co-payments, and other cost-sharing. All Medigap policies must offer certain standardized benefits, no matter what plan you have. Not all states allow you to purchase Medigap coverage if you are under 65 and have ESRD. However, if you qualify for Medicare other than because of ESRD (because you are 65 or older, for example), you can still purchase Medigap coverage in those states.

You can search for a Medigap plan in your area by using the Medicare Plan Finder, available at www.Medicare.gov/Find-A-Plan/Questions/Medigap-Home.aspx.

Medicaid, Children's Health Insurance Program and the Medicare Savings Program

Medicaid provides healthcare coverage to eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. The **Children's Health Insurance Program** (CHIP) provides healthcare coverage to eligible children through Medicaid and separate CHIP programs. Individuals or families applying for Medicaid or CHIP must meet certain income and residency requirements as well as other criteria that may be determined by each state.

States also sponsor Medicare Savings Programs (MSPs) to help pay Medicare premiums if your income falls below certain levels or if you have limited resources. In some states, MSPs can also help pay for your deductibles, co-payments and other cost-sharing under Medicare. For more detail on the income and resource levels to qualify for an MSP, please see www.Medicare.gov/Your-Medicare-Costs/Help-Paying-Costs/Medicare-Savings-Program/Medicare-Savings-Programs.html. You can also call your state Medicaid program to see if you qualify for an MSP, or consult an insurance coordinator for more information.

TRICARE and other benefits for military members and families

If you are a current or former member of the military, you and your family members may be eligible for TRICARE. For more information about the different TRICARE options available, you can use the TRICARE plan finder, available at www.TRICARE.mil/Plans/PlanFinder. Each type of TRICARE plan will mean different costs for you, including deductibles and other cost-sharing.

INSURANCE

In addition to TRICARE, veterans may qualify for healthcare benefits through the Veterans Health Administration (VA). While some eligible veterans automatically qualify for free healthcare services under the VA program, most veterans must complete a financial assessment when they enroll to determine their cost-sharing obligations. More information on member costs within the VA program is available at www.VA.gov/HealthBenefits/Cost/Copays.asp. In addition, spouses and children of certain eligible members of the military may qualify for health benefits through the VA under the U.S. Civilian Health and Medical Program of the Veterans Administration (CHAMPVA).