



Access to Care for Arthritis

Your Resource Guide to Getting Proper Coverage
For Your Arthritis and Becoming a More Powerful
Advocate for Your Own Care



Take Control. We Can Help.™

www.arthritis.org

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Did you know that 46.9 million Americans are without health-care insurance coverage, according to recent government studies?

Introduction

Nothing is more important than having access to the best health care possible, especially if you or one of your family members has arthritis or a related disease. If you currently have insurance coverage, are on Medicare, or are uninsured or underinsured, you need to know all of your options for getting care and getting coverage. More than 46 million Americans have arthritis or a related rheumatic disease, many of whom struggle to find accessible, affordable health care. Many people have no insurance coverage, have policies that do not cover enough of their costs or pay for important new arthritis treatments, or do not have qualified health-care professionals in their area to treat arthritis.

If you find insurance coverage confusing, or if you find the process of getting quality care for your arthritis frustrating, you're not alone – but you do have an advocate. The Arthritis Foundation has created this guide, *Access to Care for Arthritis*, to answer your important questions about insurance coverage and related issues for people with arthritis.

THE INFORMATION IN THIS BOOKLET WILL:

- Explain how insurance and Medicare work to help you pay for your care
- Define confusing insurance terms to help you better understand your policy and your options
- Provide guidelines and resources for getting insured, getting the help you need to pay for prescription medications and getting help when coverage is turned down
- Offer solutions to common barriers to care
- Outline how you can become your own best advocate

The Arthritis Foundation is here to ensure that you and other Americans have access to the best care possible.

Part One:



When Your Access to Care Is Limited

Almost 46 million Americans are without health insurance coverage today, and in many cases, people who have health insurance may lose their benefits due to job loss, divorce, death of a spouse, or an employer's financial troubles. Many people who have insurance find that their policies do not cover the cost of their many medical needs – particularly if they or one of their family members has arthritis.

Medical costs are not going down anytime soon. In 2007, government estimates show that the total amount Americans spent on health care was \$2.3 trillion, or \$7,600 per person, according to a report from the National Coalition on Health Care. According to the Jan/Feb. report in *Health Affairs*, health care costs more than tripled from 1990 to 2007 and are projected to rise to 25 percent of gross domestic product (GDP) in 2025, and to rise to 49 percent in 2082.

If you, your spouse, your child or other dependent has arthritis or a related disease,

costs for doctors' visits, drugs, therapy, braces, surgery and other treatments may be higher, and for some families, astronomical – thousands or tens of thousands of dollars per year. Even the best insurance policies only cover a portion of your costs for doctor's visits, drugs and other aspects of your care.

The Arthritis Foundation is working with other advocacy organizations to ensure that people with arthritis are not penalized for having a chronic disease, thus making health care and important treatments out of reach.

Whether you already have insurance or you lose your existing coverage, have to switch to a less expensive policy that doesn't cover as much, or if you simply cannot afford the premiums, deductibles and out-of-pocket costs of your arthritis care, there are resources that can offer help. The following section outlines how you can get the help you need.

IF YOU HAVE INSURANCE

If you do have health insurance benefits through your employer, your arthritis care may be covered, but you will still have to pay out-of-pocket costs and copayments for doctor's visits, drugs and other treatments. No matter what your insurance policy covers, there may still be many treatments that are only partially covered or not covered at all, including non-formulary drugs, brand-name drugs, chiropractic care, massage treatments, supplements and acupuncture. For example, your insurance policy may pay 70 percent of the costs for a brand-name drug, leaving you to pay the remaining 30 percent. If you were on a popular rheumatoid arthritis drug – which at suggested doses may cost around \$15,000-\$20,000 per year – you'd owe \$4,500 a year out of pocket. And that's just the cost of one drug. More and more, Americans are struggling to pay for health-care costs even if they do have insurance coverage.

Examine Your Policy Closely Each Year

Even if you have insurance benefits, your coverage and the out-of-pocket costs you may be responsible for may change from year to year. It's hard enough to anticipate possible unforeseen health problems, but budgeting for potential costs can be an additional challenge. It's important to stay informed so you understand the details of your insurance policy, any changes that occur from year to year (such as drugs, procedures or doctors being added or removed from coverage), or if your employer changes insurance carriers.

Understand the Difference Between Medical and Pharmacy Benefits

An insurance policy typically is composed of two parts – a medical benefit and prescription benefit. Prescription coverage may be included in the policy that you or your employer (purchaser) choose to purchase. Typically, there is an additional charge for this coverage. Generally, all of your medical services (doctor's visits, hospitalizations) are covered under the medical benefit of your insurance policy. Prescription medicines are grouped and covered by how they are administered, that is, do they require administration by a doctor or nurse or can they be self-administered (oral tablet or subcutaneous injection).

Drugs that can be self-administered are typically covered under the pharmacy benefit portion of your policy. Products such as an intravenous drug that must be administered under the supervision of a nurse or doctor would typically be covered under the medical benefit of your contract.

Biologics may be covered under the medical or pharmacy benefit under your plan. It is important that you understand what and how your policy will cover the medicine(s) that are prescribed by your doctor.

Break Through the Jargon

Are you finding it difficult to understand the language of insurance policies? Check out the Glossary at the end of this booklet to help you better understand the terms insurance companies use to explain coverage.

Know Your Options When Your Costs Get Too High

Out-of-pocket costs for arthritis treatments, doctor's visits, surgeries, or screening procedures like MRIs can be high depending on your policy and coverage. Even senior citizens who are insured through Medicare can face burdensome costs for their medical care and for their many prescription drugs. If an arthritis treatment exists but you cannot afford it with your current coverage, you may find yourself having to forgo necessary treatments, or choosing between treatments and other necessities, like food or housing. No one with arthritis should have to make this choice. That's why this guide was created – to show you some strategies for finding help when you need it, and to managing all of your healthcare costs.

The Arthritis Foundation is fighting to create new laws that cap out-of-pocket costs for important, and often life-changing drugs that currently carry copayments that are way too high for most families to afford. In many cases, people with arthritis who do have good insurance coverage still find themselves with out-of-pocket costs in the thousands of dollars for their drugs, eating away their life savings and income. The Arthritis Foundation is working with other advocacy groups to take this issue before Congressional leaders and lobby to reverse this trend.

Contact your state's insurance commissioner's office or consult its Web site to find resources and strategies for reducing your health-care cost burden and

increasing your access to the care you need. For example, if you have benefits but your insurance company is disputing a charge or is slow in paying a claim for your treatment, your state commissioner may be able to help you or explain your rights under the state's laws.

Explore mail-order or specialty pharmacy options. Your pharmacy may offer mail-order services for prescription drugs you use regularly, and in many cases, ordering in bulk through mail order can save you money. Many insurance policies also encourage you to utilize mail-order services for ongoing prescriptions and pay more of the cost when you do. Contact your insurance company to find out more about these options. You may have to use a designated mail-order pharmacy, or you may be able to use the service from most of the national pharmacy chains.

Budget ahead of time for anticipated costs. Keep track of your ongoing medical expenses, such as monthly insurance premiums or regular prescription costs, so you can be aware of the impact these charges will have on your monthly income. Personal budgeting software programs or workbooks may be able to help you create a simple monthly budget that measures your health-care costs along with other essential needs. Your insurance company even may be able to help you – some insurance companies' Web sites offer resources for creating health-care budgets, such as this one from Humana: <http://www.familyhealthbudget.com>.



Key Do's and Don'ts

DO read your policy or coverage information carefully.

DON'T be afraid to ask questions. Your insurance company should have a toll-free information number and a Web site. Call the company to ask questions or visit the Web site and email questions.

DO speak with the benefits specialist at your workplace, through your group insurance, or even at your doctor's office to explore options for getting lower premiums or better coverage for your needs.

DO explore discount programs from the company that manufactures your prescribed drug.

DO contact your insurance company directly to ask questions about getting a lower premium, more coverage under your existing premium, approval for drugs or treatments that are not included in your formulary, or to appeal denials for treatment coverage.

DO ask your doctor to help when you are denied coverage for a drug or cannot afford your portion of the costs for the drug. He or she may be able to appeal on your behalf to your insurance company.

DO ask your doctor or pharmacist if a generic drug is available and appropriate for your prescription in order to save costs or get coverage for your drug.

DON'T take no for an answer until you have explored all of your options for maintaining your coverage if you lose your benefits.

DON'T choose between paying for your medical care and paying for housing, food, utilities or other necessities. Explore all of your options and get help.

DO consult your state's insurance commissioner's office or Web site for state-specific laws and resources that help you maintain your coverage or access to care.

Explore Health Savings Accounts if you have insurance with a high deductible.

Health Savings Accounts, or HSAs, may be available to people with high-deductible(\$1,500 or higher) insurance policies to enable them to store away money on a tax-free basis to pay for later health expenses. These accounts are made with banks, credit unions, insurance companies and similar institutions. www.ustreas.gov/offices/public-affairs/hsa/faq_basics.shtml.

Explore Flexible Spending Accounts at work to pay for some medical expenses.

Flexible Spending Accounts, or FSAs, are increasingly common benefits at some workplaces. FSAs allow employees to store away money from their paychecks before taxes are taken out in a special account used to pay for approved out-of-pocket medical expenses such as copayments or coinsurance. In some cases, these expenses also may include purchases you make often for your arthritis that are not covered by your insurance policy, such as bandages, ice packs, over-the-counter medications like topical analgesic creams or aspirin, or heating pads. Costs for these items can really add up, so putting money away in an FSA can provide for these costs with tax-free income. Many FSAs provide a convenient debit card for you to use at stores to pay for purchases from this account. Ask your benefits specialist if an FSA is available.

Utilize assistance programs of the pharmaceutical industry.

Pharmaceutical companies that manufacture and sell prescription drugs want you to use their products. Most, if not all, of the manufacturers that make biologics currently provide reimbursement assistance for patients with prescription drug insurance coverage, and copayment assistance for select patients, and free goods for uninsured, pre-qualified patients.

Reimbursement specialists can provide assistance with the following:

- **Insurance verification:** Specialists will contact the payer on your behalf to verify if your arthritis prescription drug will be covered
- **Prior authorization:** Specialists will help research if your particular plan requires a prior authorization (PA) before you begin treatment. They may even help you or your doctor submit the prior authorization request
- **Denied claims:** If your insurance company has denied the drug claim, the specialists may be able to help you, or work with your doctor, to appeal the denied claim
- **Billing and coding:** Specialists assist your doctor's office with correct billing and coding information for biologics
- **Copayment assistance:** Specialists can determine if you meet specific financial and medical criteria for help with out-of-pocket costs

For a complete and up-to-date list of reimbursement copayment, coinsurance and patient assistance programs for the uninsured from the pharmaceutical industry, visit www.arthritis.org/access-to-healthcare.php.

IF YOU ARE ABOUT TO LOSE YOUR INSURANCE COVERAGE

Even if you have insurance now, your situation may change due to job loss, divorce, death of a spouse, or your employer's business problems. If you are about to lose coverage from your employer, there are options you can explore. Recent laws – and your state may have its own specific laws in addition to federal statutes – may protect you from a risky coverage gap, and also may allow you to transport your insurance coverage more easily through different life changes.

Explore COBRA Coverage if You Lose Your Job and its Benefits

COBRA laws allow you to continue your existing healthcare insurance for a set period of time if you quit or lose your job, have your work hours reduced, or get divorced and lose your spouse's coverage. Under COBRA, you are taking over the premiums once paid by a company, and these can be quite costly. However, this option may prevent a coverage gap until you get new insurance or a new job. For more information on COBRA Continuation Health Coverage laws, go to www.dol.gov/ebsa/faqs/faq_consumer_cobra.html.

Explore Protection Under HIPAA Laws

The Health Insurance Portability and Accountability Act, or HIPAA, is a federal law that improves portability and continuity of workers' health benefits, administered by the U.S. Department of Labor. HIPAA laws protect workers by limiting the types of exclusions or higher premiums they may encounter due to pre-existing conditions, or medical conditions they have prior to being

hired. This may be important for people with chronic diseases like arthritis.

HIPAA may also provide new rights for people who enroll for new health benefits when they have lost their health benefits, get married, or add a new dependent (like a child). Under HIPAA, states' laws on health-care coverage and access also take precedence over national policies, so you may benefit from the access to care that your state laws may provide. In some states, this may mean that you may make appointments with certain specialists without a referral even if you are insured by an HMO. HIPAA laws allow for more privacy in the health-care process as well, something that people with arthritis may find useful if they do not wish to be discriminated against in the workplace due to their disease. For more information on HIPAA, go to <http://www.dol.gov/ebsa/newsroom/fshipaa.html>.

Consult Your Benefits Specialist at Work or Your State's Insurance Commissioner

In today's business environment, people may not stay in their jobs for long. You may get fired, laid off, or decide to leave your job for other reasons – losing your benefits in the process. COBRA is temporary and may be expensive. Before you leave your workplace, contact the benefits specialist in the human resources department for information on your options for continuing your coverage under their policy. Or, contact your state's insurance commissioner or its Web site. In some states, laws require that the company who insured you at your previous job offer you a new policy when COBRA ends.



When You Face Denial of Coverage

Even when you have insurance, your insurance company may deny a claim. Your doctor and your pharmacist may be good resources. If you fill a prescription for your arthritis and then, upon receiving it, find out that your insurance company will not cover the drug or will only cover a small portion of the costs, your doctor may be able to formally appeal the matter with your insurance company. For example, your doctor may state that the prescribed treatment is a medical necessity, and that your insurer should cover it even though it is not included in your policy or if it has been denied previously.

The American Academy of Family Physicians has a helpful Web site with information on working with your doctor to get help with denied claims or high out-of-pocket costs for treatments: www.familydoctor.org.

Your pharmacist may also help by talking to your insurance company when you go to fulfill your prescription, or by suggesting less costly treatments for certain problems, such as generic or over-the-counter drugs. An alternative may not be available for many newer arthritis drugs, but many drugs do come “off patent” in time and are available as generics, which are far cheaper. At this time, there are no generic biologic drugs for rheumatoid arthritis and similar diseases, so out-of-pocket costs for these vital drugs can be incredibly high.

Most of the drug manufacturers also have a service available via a toll-free number that may help you, your doctor or pharmacist appeal a denied claim for a prescription drug. Be sure to utilize these resources as these programs have trained staff who understand the complexities of insurance coverage and payment.

Coverage Denial Checklist

If you are denied coverage for any prescription, treatment, medical service, surgery, specialist's office visit or any other claim:

1. Review your insurance policy first and determine if the denied treatment is expressly excluded in your policy.
2. Keep detailed notes about when you were denied, and why you were denied, for coverage, and other key facts about your case.
3. Speak to your insurance company through its toll-free customer service line for immediate response. Before you call the insurance company, having the following information readily available will help the conversation go more quickly and smoothly:
 - a. A copy of your insurance card showing the policy and group number
 - b. A copy of the Explanation of Benefit (EOB) – the form that was sent by the insurance company denying the claim
 - i. Locate the code on the form that shows why the claim was denied
 - c. The date (s) of the service (s) that were denied
 - d. The specific diagnosis for which the service was denied
4. Contact your doctor and enlist his or her help in appealing the denial. Your doctor can appeal the denial in writing. Be patient; the appeal process may take thirty days or longer to be processed.
5. Contact your state's insurance commissioner's office for more assistance in appealing the denial.
6. Consult the Web site or toll-free information line of the company that manufactures the treatment. Many pharmaceutical companies offer resources to help people whose insurers deny coverage of the treatments they produce, including on-call operators to provide guidance. (See the manufacturer resource list on www.arthritis.org/access-to-healthcare.php for this information)
7. Do not take "NO" for an answer. Be persistent in pursuing appeals for denied services or drugs. If there are no contractual limitations or specific policy exclusions under your particular insurance plan, you, along with your doctor may be able to reverse the denial decision based on the medical necessity of the service (s) or drug (s) for your arthritis.

The Kaiser Family Foundation also offers a free guide to handling disputes with your employer or private health plan at <http://www.kff.org/consumerguide/7350.cfm>.

Consult Your Attorney

If you receive health benefits through your spouse's employer, this may change if you divorce. Don't let your coverage end before discussing this as part of your divorce negotiations. You may be able to continue paying the insurance premiums and keep the coverage through COBRA, or health coverage payments may be somehow worked into your divorce settlement.

IF YOU ARE UNINSURED

If you do not have insurance at all, affording arthritis care may be difficult or impossible. There are resources to help you get insurance benefits, or to help you afford elements of your arthritis care if you cannot get benefits due to your arthritis. Depending on your age, income or social situation, you may qualify for government-provided benefits like Medicaid, Children's Health Insurance Program, Medicare or others sponsored by drug manufacturers. If you are unemployed, self-employed, or if your employer does not offer you any health benefits, you have the option of buying your own private insurance as an individual.

However, buying an individual policy when you or one of the dependents you are trying to cover has arthritis can be problematic and expensive. An insurance company does not have to insure you at all, considering you a "high-risk" individual because of your chronic illness. Or it may

insure you, but exclude coverage for your arthritis treatments through riders, or impose a waiting period before you can begin to get coverage for your arthritis treatment.

Contact Your State's Insurance Commissioner

This individual, the office staff or Web site may be able to help you find a company that will insure you, offer specific information about government-funded resources available to you in your state, and explain your state's laws on coverage and access to care for someone with a chronic illness.

Contact an Insurance Agent

If you are able to purchase an individual policy, premiums may be high. Be patient. Look at many insurance companies and policies for the most comprehensive, affordable coverage for your situation. Find independent or group insurance agents in your area through the phone directory or Internet. An insurance agent will have access to information about a wide variety of insurance companies offering individual policies to people with arthritis, and what policy will offer you the most affordable, best coverage. A local insurance agent will also know the laws in your state and how they can work to help you get coverage if you have applied for a policy and been denied because you have arthritis.

Explore Opportunities to Buy Insurance Through a Group

Buying an individual policy can be expensive, but you may be able to purchase a policy

For a complete and up-to-date list of assistance programs from the pharmaceutical industry, visit www.arthritis.org/access-to-healthcare.php.

through a group, including membership organizations (such as religious groups, alumni associations, men's or women's organizations, professional associations). If you are a member of an association or group, you will have to pay your membership dues to the group, and also pay for your policy, but you may be able to access much cheaper premiums for your policy. Find out if any associations you belong to offer group insurance – or find out if you can join one to do so.

Consider Changing Jobs

If your current employer does not offer health benefits, consider looking for employment that does come with insurance. It's likely that insurance provided by an employer, or even purchased by you

through your employer's membership with the insurance provider, will provide more comprehensive coverage for your arthritis treatments, including drug costs, X-rays, therapy and other needs. Most insurance carriers waive any restrictions on pre-existing conditions like arthritis for policies provided through an employer.

Utilize Assistance Programs of the Pharmaceutical Industry

Most drug manufacturers have programs that offer their products, free-of-charge, for certain patients who meet specific financial and medical criteria. Be sure to investigate these resources to determine if you qualify for assistance through one of these programs.

Understanding the Term “Pre-existing Condition”

A term you may hear as you explore insurance coverage options is “pre-existing condition.” A pre-existing condition is any health condition or problem – including diagnosed diseases like arthritis or diabetes, or health conditions like high blood pressure or chronic headaches – that you have at the time you apply for an insurance policy, or have had in the past, and may have sought medical attention to treat.

A policy may exclude covering any costs related to treatments for these pre-existing conditions indefinitely, or it may have a waiting period where you will

not be covered for treatments for these conditions during that time frame. In most cases, if your insurance comes through your job, there is a time limit on how long your employer's insurer can exclude coverage for your pre-existing conditions.

In many cases, insurers providing group coverage through an employer cannot exclude individual employees' pre-existing conditions at all – they may only be able to offer blanket coverage in the group's policy. Individuals seeking policies are at greater risk of finding their arthritis care excluded or limited in insurance policies.

Learn About Patient Assistance Services for the Uninsured

Assistance programs are available for people without insurance to provide free or discounted prescription drugs if you qualify.

In addition to funding and providing independently sponsored reimbursement and other assistance programs for their own specific drugs, some manufacturers have banded together to form an alliance called Partnership for Prescription Alliance (PPA). As with their own independently supported programs, the PPA was established to help qualified patients who may lack coverage gain access to the drugs they need. The PPA may also be able to advocate on your behalf with your insurance company when you are denied coverage in some cases. However, unfortunately, at this time, this program does not cover biologic drugs, but many other prescription drugs used to treat arthritis are included, including celecoxib and leflunomide. Information on PPA can be found at www.pparx.org

The Together Rx Access, LLC is an initiative to help uninsured Americans gain access to prescription products at significant savings. Using the Together Rx Access Card, eligible patients can

also save on prescription medicines and generic products at pharmacy counters.

Through the Together Rx Access Card, the participating companies offer savings on more than 300 brand-name prescription medicines and products, as well as a wide range of generic products, right at pharmacy counters. These products include those used to treat arthritis.

Eligible uninsured individuals can expect to save approximately 25 to 40 percent, and sometimes more, on these prescription products directly from the manufacturers. Participating companies independently set the level of savings offered and the products included in the program. Those decisions are subject to change. Together Rx Access also can help direct individuals to various resources for help on obtaining coverage or products. Unfortunately, biologics are not covered but many other prescription drugs used to treat arthritis are included. For more information, visit www.togetherrxaccess.com or call 1-800-444-4106.

For a complete and up-to-date list of assistance programs, visit www.arthritis.org/access-to-healthcare.php.

Did you know that recent national studies show that as many as 25 million Americans who do have insurance have policies that may cover only a portion of their medical costs, leaving them with expensive bills for prescriptions and other treatments?



Part Two:



Moving Into Medicare

For millions of American citizens who struggle to pay for health care, approaching age 65 can bring a sense of excitement and relief. At 65, American citizens are eligible for Medicare coverage, along with some disabled people under 65 and people with end-stage renal disease. However, while Medicare can provide extensive coverage for your healthcare needs, understanding your benefits under Medicare can be confusing.

MEDICARE HAS SEVERAL PARTS:

Part A - Hospital Insurance, to cover costs of inpatient hospital treatment or stays, or treatments in skilled nursing facilities, hospices or some home health care. Guidelines to qualify for home care are very rigorous. You should check with your doctor's office, hospital or directly with Medicare if you are seeking care in the home.

Part B - Medical Insurance, to cover outpatient care and doctor's services, as well as preventive care to maintain your health and prevent illnesses from getting worse

Part C - Medicare Advantage Plans, like HMO and PPO plans, that you may choose to utilize from private health-care companies

Part D - Prescription Drug Coverage, to help cover the costs of your prescription drugs

UNDERSTANDING MEDICARE COVERAGE

If you or your spouse paid Medicare taxes as part of the taxes taken out of your paycheck each month during the years that you worked, then in many cases you can get basic Medicare Part A coverage without paying premiums. Otherwise, you might have to pay premiums for this coverage. In addition, if you choose to add to the basic Medicare coverage and have more flexibility in choosing doctors or accessing services, you can pay for more coverage, such as the Medicare Advantage Plans. You will have to pay a monthly premium for Medicare Part B, which covers doctor's office visits; the standard 2009 premium increases each calendar year.

To get prescription drug coverage through Medicare Part D, you must join a plan administered by a health-insurance organization or private insurance company approved by Medicare. If you choose to purchase prescription drug coverage through Medicare, you will have a wide range of options from which to choose when making your selection. There will be an additional cost to purchase the coverage, and there may be significant out-of-pocket expenses also. If you have limited income or resources (as many retired people do), there are programs, including federal and state, that may help you afford your drugs.

If you qualify for Medicare – such as if you are approaching age 65 or have applied for and received legal disability status from the government – you will automatically receive notice of your coverage from Medicare. Three months before your 65th birthday, or in your 25th month of disability, you would receive a Medicare card in the mail. If you are not yet receiving Social Security benefits – for example, if you are turning 65 but are still working at your job – you may have to sign up for Medicare Part A by contacting the Social Security Administration at 1-800-772-1213 three months before your 65th birthday.

It's impossible to explain all the aspects of the Medicare program in this guide, but Medicare has a new, comprehensive online guidebook to its programs and services to explain the program's parts, its coverage and its costs. "Medicare and You: 2009" also includes a section of information for

people with limited income or financial resources and how they can get help in affording their health-care coverage and costs: www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

Prepare for entering the “doughnut hole”
Medicare's Part D includes a coverage gap, or what many people call the “doughnut hole.” If you have Medicare, your drug costs are covered up to a certain limit – above that limit, you become responsible for the costs of your drugs until your annual costs reach another high or “catastrophic” limit, above which Medicare again covers 95 percent of the costs and you pay 5 percent. Costs are calculated on a calendar year basis.

For example, in 2007, Medicare Part D paid 75 percent of your prescription drug costs up to \$2,400; you paid 25 percent of the bill. Once your total drug costs reached \$2,400, you were responsible for 100 percent of the drug costs until the total annual costs reached \$5,451.

If you have Medicare coverage, but are also retired and on a fixed income (and many people over 65 have seen their retirement savings go way down in the recent stock market downturns, which drained investment accounts), paying arthritis drug bills in the thousands can be hard or impossible. Many seniors go without their medicine, take it less often, or split pills to stretch out each costly prescription. This is a major problem for many people with arthritis, and the Arthritis Foundation is

committed to efforts to address this issue in the current health care reform debate to make arthritis drugs affordable for seniors.

In 2009, Medicare Part D set the catastrophic level lower, at \$4,350 for the calendar year. You are still responsible for paying a deductible of \$295; Medicare pays 75% up to \$2,700 and you are responsible for paying 100% of the costs for drug costs between \$2,700 and \$4,350. Thereafter Medicare pays 95% of the costs and you are responsible for 5%. If you're worried about affording drugs while in the doughnut hole, Medicare provides some suggestions in its free online publication, "Bridging the Coverage Gap," which you may find at www.medicare.gov/Publications/Pubs/pdf/11213.pdf. You will find more detailed information about Medicare's drug

coverage and when you may fall into this coverage gap on their Web site.

When Do I Join Part D?

You can sign up or change your Medicare Part D plan between November 15 and December 31 each year. Your coverage will begin on January 1 of the new year. You should enroll the year you are eligible, or you may have to pay more if you decide to join later.

How Do I Choose a Plan?

Medicare has information that can help you compare the plans. You can get this info at www.medicare.gov or 1-800-MEDICARE (1-800-633-4227). You should have also received a handbook called "Medicare & You" in the mail.



Did you know that most of the millions of underinsured are working, middle-income Americans?



Part Three:

Barriers to Care

Insurance is not the only issue affecting Americans' access to care. Many people with arthritis do have insurance, whether through private insurance companies or public insurance programs like Medicare or Medicaid. What they do not have is easy, efficient access to good care and treatments for their disease. Why?

PHYSICIAN AVAILABILITY

There are numerous barriers that keep people from getting access to arthritis care. One of the most crucial problems you may face is that there are too few rheumatologists, the specialists who treat arthritis and other rheumatic diseases, as well as far too few pediatric rheumatologists, the specialists who treat children and adolescents with rheumatic diseases. In some areas of the country, the nearest rheumatologist or pediatric rheumatologist may be hours away by car. Some states have no pediatric rheumatologist at all, making it very time-consuming and expensive (particularly with unpredictable gasoline prices) for

parents of a child with juvenile arthritis to seek quality care. If you live in a larger metropolitan area that does have several rheumatologists, pediatric rheumatologists, or even a hospital or university health center with a rheumatology clinic, you may still face long waits for an appointment in some cases, because there are still too few trained professionals to see too many patients. In some cases, you may have to wait weeks or months for an appointment. The wait can mean delays in treatments like biologic drugs that may prevent permanent joint damage, so increasing the professional workforce is key.

Organizations such as the Arthritis Foundation, the American College of Rheumatology (the professional association of rheumatologists) and the Association of Rheumatology Health Professionals (the professional association of other health-care professionals treating arthritis and rheumatic diseases) are focused on addressing this professional workforce shortage issue, funding fellowships to

train new rheumatologists and pediatric rheumatologists, and providing education to medical students and others in training to teach them more about treating people with arthritis and rheumatic diseases.

TRANSPORTATION

Another possible barrier to care you may face is transportation. Many people today, including many seniors, don't have a car or cannot drive on their own to their medical appointments. If you have mobility issues, using public transportation can be exhausting and painful. Here are a few suggestions:

- Many public transportation services include van or shuttle services for people with physical challenges. Check your local service's Web site or call them to access these services.
- Contact your local government health services department to find out if they include free transportation services for medical appointments.
- If your doctor's office is located at a hospital, find out if the hospital offers a medical transportation service for outpatient services.
- Contact local social service organizations, such as religious or community groups, to see if they have a volunteer medical transportation car service.
- Unless you are having a medical emergency, don't call an ambulance for transportation to a normal medical appointment. These services are meant for emergencies only, and are costly.

COMMUNICATION

In many cases, doctors and other health-care professionals struggle to communicate with an increasingly diverse patient population. Doctors may see patients who do not speak English, and may speak Spanish, Vietnamese, African dialects, Russian or other languages instead. Even if the doctor and the patient share a few phrases in each others' languages, discussing and understanding symptoms, treatment instructions and other key information can be difficult.

Even if you speak English, you may not understand the medical jargon your doctor uses, leading to mistakes in how you take your drugs or follow your treatment regimen. Or, your doctor may not fully understand your description of your symptoms – a problem that is especially difficult in treating children.

Don't be afraid to ask your doctor to repeat instructions or explain them in "plainer" language. It's important that you understand how to take your medications properly. In addition, write down any descriptions of your symptoms, as well as questions you have for your doctor, before you get to your appointment. Take a trusted family member or friend with you. If you're a parent of a child with juvenile arthritis, sit down with your child beforehand to write down any symptoms or questions you may have. Once you fill a prescription, speak with the pharmacist if you have any questions about how to take the medication. Or call your doctor's office and let them know your questions.

WORKPLACE CULTURE

If you have arthritis, having a job in an understanding, flexible work environment is helpful. Most importantly, being employed may mean that you can get good health insurance even with a pre-existing condition like arthritis. However, you may need special accommodations at work, such as a modified computer keyboard or more supportive desk chair. You may need to get up from your work station more often than others to stretch to avoid the stiffness that may accompany arthritis. You may experience flares at times, meaning that you have to take time off from work for rest, recovery or medical appointments.

There are laws, like the Americans with Disabilities Act, which protect your rights in the workplace, ensuring that in many cases you can receive modifications that allow

you to do your job and get medical care or rest when you need it. Information on your rights under the act are on its Web site, www.ada.gov.

If your supervisor makes you feel as if you are lazy or needy for taking time for your doctor's appointments or for stretching in the middle of the day, don't avoid doing what is best for your arthritis in order to fit in or please your boss. Don't be afraid to stand up for your rights, and explain your needs to your supervisor and coworkers, emphasizing your commitment to your work as well.

For more information on this subject, contact the Arthritis Foundation at www.arthritis.org or 1-800-283-7800 and ask for a copy of the FREE brochure *Arthritis in the Workplace*.



Part Four:



Be Your Own Advocate for Access to Care

You must be your own advocate for better access to arthritis care. This guide has provided resources, suggestions and strategies for improving your access to good health care for arthritis and managing the costs associated with it. As you learned, the Arthritis Foundation is working to promote legislation that improves your access to care and your rights to have a productive life with arthritis. If you'd like to get involved as well, here are some suggestions:

- **Become an Arthritis Advocate in your community.** Contact your local Arthritis Foundation chapter by logging on to www.arthritis.org or calling 1-800-283-7800 to find your nearest office. Sign up to be an Arthritis Advocate. You can write letters to representatives, speak in your community, volunteer for local health information events, or even travel to Washington, D.C., for annual Advocacy Day events on Capitol Hill. For more information on becoming an Arthritis Advocate, go to www.arthritis.org/inside-advocacy.php.
- **Stay informed.** Go to the Arthritis Foundation's Web site, www.arthritis.org, for regular updates on legislative news affecting people with arthritis and their access to care. Recently Arthritis Foundation volunteers, advocates and staff, along with other nonprofit organizations, have advocated for the passage of the Arthritis Prevention, Control and Cure Act, an important piece of legislation which will ensure the government's commitment to promoting public health initiatives for people with arthritis and addressing the pediatric rheumatologist workforce shortage issue.
- **Donate to the Arthritis Foundation's efforts.** You may donate to the Arthritis Foundation and help support ongoing advocacy and lobbying efforts by volunteers. Go to www.arthritis.org or call 1-800-283-7800 for more information.
- **Contact your representative.** If you have concerns about your access to care, or if you face problems with insurance

coverage, reimbursement or other issues, contact your representative to Congress and let them know these issues are affecting your community. To find your representative, go to www.house.gov and enter your information. Grassroots advocacy creates change – and that means that people like you are making your voices heard to the people who represent you in government to create change in policies.

The Arthritis Foundation is committed to improving your access to care. Contact us, including your local chapter, for information and help. The Arthritis Foundation's Web site, www.arthritis.org, offers helpful information and resources for people with arthritis who struggle to gain access to care and to get coverage for their arthritis treatments. If you have been denied coverage for an arthritis drug, it's likely you are not alone among the 46 million Americans who have arthritis or a related disease.

Don't forget to utilize the resources that the drug manufacturers have developed to support your access to biologic drugs. In addition, your local chapter of the Arthritis Foundation may have heard similar complaints from people in your area, and may be able to suggest ways to fight for your access to the care you need. Call 1-800-283-7800 or go to www.arthritis.org to get free information or to find your local chapter office. Take control of your arthritis and your care. We can help.



Did you know
that the Arthritis
Foundation advocates
on behalf of people
like you to promote
legislation to improve
your access to medical
care and your access
to comprehensive
insurance coverage
to pay for that care?

Part Five:

Glossary of Terms



Insurance policy terms can be unfamiliar and confusing. However, you need to understand your policy and its provisions when dealing with your insurance company, human resources or benefits specialists at work, government representatives or the benefits staff at your doctor's office. Here, you'll find an easy glossary of terms explaining some of the most common options for coverage, and important terms to know.

COBRA: The Consolidated Omnibus Budget Reconciliation Act, a law that allows you to continue your existing health-care insurance for a set period of time. For example, if you leave your job, you have the opportunity to keep your coverage, taking over the premiums yourself. COBRA provides you a temporary stopgap (usually 18 months) until you find new coverage, but it can be expensive. Information on the COBRA law and your rights may be found on the Department of Labor's Web site, www.dol.gov/ebsa/cobra/html

CAPITATION: Capitation represents a set dollar limit that you or your employer pay to a health maintenance organization (HMO), regardless of how much you use (or don't use) the services offered by the health maintenance providers. (Providers is a term used for health professionals who provide care. Usually providers refer to doctors or hospitals. Sometimes the term also refers to nurse practitioners, chiropractors and other health professionals who offer specialized services.)

COINSURANCE: The percentage of the payment of costs beyond your deductible that you pay, along with a percentage that your insurance company pays, up to a predetermined "stop-loss" point. For example, you may have to pay 30 percent of medical costs beyond your deductible up to a certain amount, at which point your insurance company would have to pay. With increasing frequency, people with arthritis who take expensive biologic drugs are being exposed to very high coinsurance payments that might run into the thousands.

COPAYMENT: A set fee or dollar amount (for example \$20, \$40 or other dollar amount) that you pay for a medical office visit, services or medications. Copayments must be paid at the time of your visit. In some policies, copayments may vary depending on if you choose to use a health-care professional, clinic or hospital on an approved “in-network” list or not. In addition to your copayment, you may be responsible for all or a portion of the remaining cost of the service, depending on your policy and the service you receive. Some services may not be covered under your particular policy, so read the fine print. In many cases, you might be billed later for additional costs that are not covered by your insurance.

DEDUCTIBLE: A set, limited amount that you must pay for certain medical care services per year. For example, if your insurance policy has a \$1,000 deductible, and you receive care from the emergency room after a fall, you would have to pay up to \$1,000 of the cost of the care you receive. After you have reached your annual deductible limit, your insurance provider must cover the additional costs, although you may still be required to pay copayments for some services. Services that count toward your deductible vary from policy to policy.

DISABILITY INSURANCE: Additional coverage policies that also pay short-term income in the event that you cannot work due to illness or injury. Such policies may be provided by employers, or purchased by individuals.

EFFECTIVE DATE: The date your insurance is to actually begin. You are not covered until the policy’s effective date.

EMPLOYEE ASSISTANCE PROGRAMS (EAPS): Mental health counseling services that are sometimes offered by insurance companies or employers. Typically, individuals or employers do not have to directly pay for services provided through an employee assistance program.

EXCLUSIONS: Medical services that are not covered by an individual’s insurance policy.

EXPLANATION OF BENEFITS: The insurance company’s written explanation to a claim, showing what they paid and what the client must pay. Sometimes accompanied by a benefits check.

FORMULARY: The list of approved, covered drugs in any insurance plan. If your prescribed drug is not on your plan’s formulary, you may have to pay all or part of the cost of the drug. If your plan does not list a specific drug on its formulary, there are things that you can do, and steps that you can take, to add a specific drug to the formulary. These steps include working with your employer to request a waiver or exception for a specific class of drugs, or submitting an exception request based on medical necessity directly to the insurance plan. You may want to consider involving your doctor in requesting an exception to the formulary list of drugs based on the medical necessity of the product for your specific condition.

GENERIC VS. BRAND-NAME DRUGS:

Generic drugs are drugs that are sold without the protection of an exclusive patent, meaning that many companies can produce and sell the product. Brand-name drugs are produced with patent protection, which means only the company holding the patent may sell it in the United States. Patents only last for a set period of time, after which the drug may be produced widely by many companies. Brand-name drugs cost more because the company producing it has exclusivity and, usually, is recouping its costs from research and development to create the drug, as well as marketing costs. Generic drugs usually cost much less. Most insurance plans prefer generic drugs when they are available, costing you much less out of pocket. If your drug (like most drugs for RA and other rheumatic diseases) is only available as a brand-name product, your out-of-pocket costs may be quite high – or your insurance company may not cover it at all. Resources in this guide will show you ways to find help paying for your drugs.

HMO: Health maintenance organization, a type of managed care organization where you must seek health-care services from physicians or institutions (such as hospitals or clinics) that are part of the HMO's approved list. The HMO has a contract with these professionals and institutions, and usually, the doctors or institutions must follow a determined course of treatment set by the HMO. In many HMOs, you must see your chosen primary-care physician (usually

a general practitioner, internist or family physician) for all non-emergency medical conditions. If she/he determines that your condition needs to be treated by a specialist, such as a rheumatologist, she/he must make a referral so your visit to the rheumatologist to be covered. HMOs may provide less flexibility than a PPO, but premiums and out-of-pocket payments for treatment or services are often less. In addition, state laws vary on whether or not HMO members must get referrals before making appointments with specialists, so check your state insurance commission's Web site for more information.

INDIAN HEALTH SERVICE: Native Americans and Native Alaskans who are enrolled members in a federally recognized tribe may be eligible to receive health benefits from the Indian Health Service, or IHS, which is administered by the federal government. In addition, other individuals (such as non-Indian women pregnant with a part-Indian child) may be eligible for services. For more information on IHS, go to www.ihs.gov.

INDIVIDUAL, GROUP AND EMPLOYER-PROVIDED: The nature of your insurance policy arrangement. If you purchase your own insurance policy as an individual, or as part of a group of which you are a member, you pay the monthly premiums and out-of-pocket costs for your health care. If you receive health benefits through their employer, your employer usually pays all or a portion of the monthly premiums, but you must pay for copayments,

deductible and out-of-pocket costs. In some cases, employees may pay all of their premiums, but at lower costs due to their employer's group policy. Employees may also purchase additional policies to cover a spouse, children or other dependents.

INPATIENT VS. OUTPATIENT: Inpatient visits to hospitals or clinics for surgeries or treatments include you being admitted to the hospital and, in most cases, staying for one or more nights. Outpatient services include treatments you have at your doctor's office, a clinic or a hospital where you are not admitted and do not stay overnight.

IN-NETWORK VS. OUT-OF-NETWORK: Doctors and other health-care providers, or institutions like hospitals or clinics, that are in-network have a special agreement with your insurance company and are on an approved list. By using these services, you will pay less out-of-pocket costs for your care. Health-care providers or institutions that are out-of-network are not on that list, and do not have an agreement with your insurer. Therefore, you may have to pay more or all of the costs of using their services if you choose.

LIFETIME MAXIMUM BENEFIT (OR MAXIMUM LIFETIME BENEFIT): the maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

LIMITATIONS: a limit on the amount of benefits paid out for a particular covered expense, as disclosed on the Certificate of Insurance.

LONG-TERM CARE POLICY: Insurance policies that cover specified services for a specified period of time. Long-term care policies (and their prices) vary significantly. Covered services often include nursing care, home health care services, and custodial care.

LONG-TERM DISABILITY INSURANCE: Pays an insured a percentage of their monthly earnings if they become disabled.

LOS: LOS refers to the length of stay. It is a term used by insurance companies, case managers and/or employers to describe the amount of time an individual stays in a hospital or in-patient facility.

MANAGED CARE: A medical delivery system that attempts to manage the quality and cost of medical services that individuals receive. Most managed care systems offer HMOs and PPOs that individuals are encouraged to use for their health care services. Some managed care plans attempt to improve health quality by emphasizing prevention of disease.

MAXIMUM DOLLAR LIMIT: The maximum amount of money that an insurance company (or self-insured company) will pay for claims within a specific time period. Maximum dollar limits vary greatly. They may be based on or specified in terms of types of illnesses or types of services. Sometimes they are specified in terms of lifetime, sometimes for a year.

MEDICAID: Federal government-provided health insurance provided to eligible individuals and families of low income or financial resources. Medicaid is also administered by CMS, and payments for services are paid directly to health-care providers. Children who are either U.S. citizens or lawfully admitted immigrants, people in nursing homes and disabled children may also be eligible for Medicaid. Extremely high medical expenses, which often accompany severe arthritis, especially in children, may not make you automatically eligible for Medicaid, however. For more information on Medicaid, go to www.cms.hhs.gov/home/medicaid.asp.

MEDICARE: Federal government-provided health benefits provided to American citizens and permanent legal residents of more than five continuous years who are 65 years of age and older. In addition, younger people who are legally disabled for at least 24 months and have certain serious medical conditions (such as end-stage renal disease) may be eligible for Medicare. The U.S. Center for Medicare and Medicaid Services, or CMS, administers this program, and contracts with private health-care companies such as Aetna, Blue Cross/Blue Shield, Humana to help them administer this program. Depending on your situation, you may have to pay premiums on Medicare, as well as coinsurance or out-of-pocket costs for certain services or drugs. The Social Security Administration (SSA) determines your eligibility for Medicare and processes premium payments. Medicare

includes several parts that cover different health-care needs or offer different options for your coverage, chiefly Part A (hospital stays) and Part B (medical insurance), Part C (Medicare Advantage Plans or options to receive additional coverage through private insurance) and Part D (prescription drug coverage). For more information on Medicare, go to www.medicare.gov, where you will find thorough information and updates on coverage.

MEDIGAP INSURANCE POLICIES:

Medigap insurance is offered by private insurance companies, not the government. It is not the same as Medicare or Medicaid. These policies are designed to pay for some of the costs that Medicare does not cover.

NETWORK: A group of doctors, hospitals and other health care providers contracted to provide services to insurance companies customers for less than their usual fees. Provider networks can cover a large geographic market or a wide range of health care services. Insured individuals typically pay less for using a network provider.

OUT-OF-PLAN (OUT-OF-NETWORK):

This phrase usually refers to physicians, hospitals or other health care providers who are considered nonparticipants in an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual's insurance company.

OUT-OF-POCKET COSTS: Costs you must cover up front for certain medical services or products. For example, your insurance policy might pay for 70 percent of your prescription drug costs, but the other 30 percent must be paid by you as an out-of-pocket cost. Or you may have an annual deductible of \$250 which you will have to pay out-of-pocket, and up front, before your insurance policy will pay for any services.

OUT-OF-POCKET MAXIMUM: A predetermined limited amount of money that an individual must pay out of their own savings, before an insurance company or (self-insured employer) will pay 100 percent for an individual's health care expenses.

POS: Point of service plans, health insurance programs that combine various aspects of HMO and PPO plans. For example, if you belong to a POS plan, you might not have to choose whether to use an in-network doctor and seek a referral to an in-network specialist, or to go outside the network and pay more for this service, until the time when you actually need the service.

PPOS: Preferred provider organization, a type of managed care organization where you may utilize the health-care services from professionals (including doctors, physical therapists or other health-care providers) either in or out of a preferred list. However, the cost you pay for each office visit or service is higher if you choose to use a professional or institution not on the preferred list. In addition, monthly premiums, or payments you or your

employer are charged to have the insurance coverage, may be higher if you enroll in a PPO. Still, many people choose to pay more to belong to a PPO so they can choose the doctor or hospital they prefer.

PRE-ADMISSION CERTIFICATION:

Also called pre-certification review, or pre-admission review. Approval by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or in-patient facility, granted prior to the admittance. Pre-admission certification often must be obtained by the individual. Sometimes, however, physicians will contact the appropriate individual. The goal of pre-admission certification is to ensure that individuals are not exposed to inappropriate health care services (services that are medically unnecessary).

PREMIUMS: A monthly payment or fee for your insurance policy. The amount of the premium varies from policy to policy, based on the type or amount of coverage you have, and any pre-existing conditions you may have.

PRE-ADMISSION REVIEW: A review of an individual's health care status or condition, prior to an individual being admitted to an inpatient health care facility, such as a hospital. Pre-admission reviews are often conducted by case managers or insurance company representatives (usually nurses) in cooperation with the individual, his or her physician or health care provider, and hospitals.

PRE-ADMISSION TESTING: Medical tests that are completed for an individual prior to being admitted to a hospital or inpatient health care facility.

PRIMARY CARE PROVIDER (PCP): A health care professional (usually a physician) who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a “quarterback” for an individual's medical care, referring the individual to more specialized physicians for specialist care.

PRIVATE INSURANCE AND MANAGED CARE: Insurance supplied by a private insurance company, rather than by the government. Private insurance coverage may come through your employer, or may be purchased by you individually or as part of organizations or groups where you may be a member, such as organizations of self-employed people, or nonprofit organizations. Managed care is a term describing the type of private insurance organization that provides your coverage, and can also refer to the type of plan you have, including health maintenance organizations (HMO), preferred provider organizations (PPO), and point-of-service plans (POS), all further explained below.

PROVIDER: Provider is a term used for health professionals who provide health care services. Sometimes, the term refers only to physicians. Often, however, the term also refers to other health care professionals such as hospitals, nurse practitioners,

chiropractors, physical therapists, and others offering specialized health care services.

PUBLIC INSURANCE: Government insurance programs such as Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), Military/Veterans Health Administration (VA) and Indian Health Service (HIS). These programs offer individuals who qualify due to age, income level, veterans' status or membership in a Native American tribal group health services at greatly reduced costs, and is funded through tax dollars. Some programs are administered by branches of the federal government, while others are administered by your state.

RIDER: A special provision or amendment to your insurance policy that allows your insurance company to either expand or reduce its coverage in certain cases. Riders make your policy specific to your needs, or may mean that your insurance coverage may change if you need care for certain conditions, such as arthritis. People with arthritis who get individual health policies may find that their arthritis-specific care may not be covered or may be covered at more out-of-pocket cost, so be aware of riders in your policy.

CHIP: The Children's Health Insurance Program is jointly financed by the federal and state governments, and is administered by the states. Eligibility, coverage and payments may vary from state to state. Families who have too much income or

assets to qualify for Medicaid (usually with children under 19 and income of up to \$32,600 for a family of four) may be eligible for CHIP. For little or no cost to the family, CHIP may pay for your child's doctors' visits, immunizations, hospitalizations or emergency room visits. For more information on CHIP, go to www.cms.hhs.gov/LowCostHealthInsFamChild.

SECOND OPINION: It is a medical opinion provided by a second physician or medical expert, when one physician provides a diagnosis or recommends surgery to an individual. Individuals are encouraged to obtain second opinions whenever a physician recommends surgery or presents an individual with a serious medical diagnosis.

SECOND SURGICAL OPINION: These are now standard benefits in many health insurance plans. It is an opinion provided by a second physician, when one physician recommends surgery to an individual.

SHORT-TERM DISABILITY: An injury or illness that keeps a person from working for a short time. The definition of short-term disability (and the time period over which coverage extends) differs among insurance companies and employers. Short-term disability insurance coverage is designed to protect an individual's full or partial wages during a time of injury or illness (that is not work-related) that would prohibit the individual from working.

SHORT-TERM MEDICAL: Temporary coverage for an individual for a short period of time, usually from 30 days to six months.

SMALL EMPLOYER GROUP: Generally means groups with 1 to 99 employees. The definition may vary between states.

STATE MANDATED BENEFITS: When a state passes laws requiring that health insurance plans include specific benefits.

STOP-LOSS: The dollar amount of claims filed for eligible expenses at which which point you've paid 100 percent of your out-of-pocket and the insurance begins to pay at 100 percent. Stop-loss is reached when an insured individual has paid the deductible and reached the out-of-pocket maximum amount of co-insurance.

SUPPLEMENTAL INSURANCE: Additional coverage policies purchased either by individuals or through group plans as additional coverage in the event of a more serious or long-term illness or injury. Supplemental insurance may provide short-term cash benefits to help you pay medical bills, living expenses while you are unable to work or earn your normal income, and other needs. Some employers offer their employees the opportunity to purchase a supplemental insurance policy in addition to their standard health-care coverage.

TRIPLE-OPTION: Insurance plans that offer three options from which an individual may choose. Usually, the three options are traditional indemnity, an HMO, and a PPO.

UNDERWRITER: The company that assumes responsibility for the risk, issues insurance policies and receives premiums.

USUAL, CUSTOMARY AND REASONABLE (UCR) OR COVERED EXPENSES: An amount customarily charged for or covered for similar services and supplies which are medically necessary, recommended by a doctor, or required for treatment.

VETERANS/MILITARY HEALTH SYSTEM AND TRICARE: Federal government-provided health services for active duty and retired U.S. military personnel and their dependents. This program also has a managed care component called TRICARE, which provides civilian health benefits to you if you fall into this eligible group. TRICARE contracts with particular civilian health-care providers or institutions to provide care to its members. For more information on available benefits if you are in this group, go to <http://www.tricare.mil>.

WAITING PERIOD: A period of time when you are not covered by insurance for a particular diagnosis. This time frame may vary from 30 days to two years depending on your insurance policy.

Health Care Resources

REIMBURSEMENT, CO-PAYMENT, OUT-OF-POCKET ASSISTANCE AND DRUG DISCOUNT PROGRAMS

Chronic Disease Fund

- www.cdfund.org/patient
- Toll-Free Patient Information: 1-877-968-7233

The HealthWell Foundation

- www.healthwellfoundation.org/how-to-apply.html
- Toll-Free Patient Information: 1-800-675-8416

Partnership for Prescription Assistance (PPA)

- www.pparx.org
- www.pparx.org/es/ (spanish)
- Toll-Free Patient Information: 1-888-4PPA-NOW (477-2669)

TogetherRX Access Card

- www.togetherrxaccess.com
- Toll-Free Patient Information: 1-800-444-4106

Non-Oncology Medications

- www.bridgestoaccess.com
- Toll-Free Patient Information: 1-866-PATIENT (1-866-728-4368)

REIMBURSEMENT, CO-PAYMENT, OUT-OF-POCKET ASSISTANCE, AND PATIENT ASSISTANCE PROGRAMS FOR BIOLOGICS

Enbrel® (etanercept):

- www.enbrel.com
- Toll-Free Patient Information: 1-888-436-2735 for reimbursement assistance
- www.encouragefoundation.org
- Toll-Free Patient Information: 1-800-282-7752 for uninsured or underinsured assistance

Humira (adalimumab):

- www.humira.com/Global/FinancialHelp/Default.aspx
- Toll-Free Patient Information: 1-800-448-6472 for reimbursement assistance
- Toll-Free Patient Information: 1-800-222-6885 for uninsured or underinsured assistance

Remicade® (infliximab):

- www.remicade.com (select “getting support”)
- Toll-Free Patient Information: 1-888-222-3771 OR 1-866-489-5957 (option 1)

Rituxin® rituximab:

- www.gene.com/gene/about/community/access.html
- Toll-Free Patient Information: 1-866-681-3261 for reimbursement assistance
- Toll-Free Patient Information: 1-866-681-3320 for uninsured or underinsured assistance

Raptiva (efalizuma):

- www.genentechaccessolutions.com
- Toll-Free Patient Information: 1-866-480-7762 for reimbursement assistance
- Toll-Free Patient Information: 1-800-280-8938 for uninsured and underinsured assistance

Orencia® (abatacept):

- www.orencia.com
- Toll-Free Patient Information: 1-866-268-4514 for reimbursement assistance
- Toll-Free Patient Information: 1-800-675-8416 for uninsured or underinsured assistance

Kineret® (anakinra):

- www.kineretrx.com/patient
- Toll-Free Patient Information: 1-866-547-0644 for reimbursement and patient assistance

For more extensive and up-to-date information and resources concerning access to care for people with arthritis, visit www.arthritis.org/access-to-healthcare.php.



www.arthritis.org