Cornerstones4Care®

Understanding health insurance

Your reference guide

novo nordisk®

This booklet belongs to:

Name

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If this booklet is found, please contact the owner listed above. Thank you!

This booklet does not replace the advice of your diabetes care team. Be sure to consult your diabetes care team regarding your individual diabetes care plan.

What's inside

What you need to know about health insurance

Why is it important to know about health insurance?

Taking care of your health means many things.

- It means working with your diabetes care team and other health care providers
- It means taking your medicines as prescribed
- It also means learning about **health insurance**—about your health insurance options if you are not yet insured, and about your health insurance coverage if you are insured

Health insurance is important for everyone. If you have diabetes, an insurance plan may help provide coverage for what you need to manage your diabetes, including medical care, medicines, and supplies, such as test strips, meters, and insulin.

There are both private and public health insurance plans, with different plans offering different **benefits**. Also, everyone's health care needs are different. That is why choosing a health insurance plan that is right for you, and understanding how it works, may seem confusing.

The goals of this booklet are to:

- Explain the basics of health insurance and how it works
- Point out some things to look for in a health insurance plan
- Suggest what things to consider and what questions to ask when choosing a health insurance plan
- Inform you about programs that are available to help eligible people pay for **prescription medicines**
- Provide resources to help you learn more about health insurance

You will find a list of terms at the back of this booklet. If you come across words that you're not sure about, check the list for definitions.

Something to make it easier

Some of these words can be hard to understand! If you come across a term you're not sure about, check the glossary at the back of the book. All of the terms printed in **green** in this book are defined there.

What is health insurance?

Health insurance is a contract between you and your health insurer to cover your medical expenses. Your health insurance company helps pay for some or all of your medical care, depending on the type of insurance plan you have. Talk with your diabetes care team to find out what parts of your care are covered by your plan.

Quick tip

It is important for you to know which medical costs a plan will cover and which medical costs it will not.

JASON M. AND ZOLIA L.
Zolia's husband Jason has type 2 diabetes

What services might health insurance cover?

Depending on your plan, health insurance might cover:

- Visits to a health care provider's office or clinic
- Preventive care, such as checkups, screening tests, and vaccines
- **Hospital outpatient care**
- X-rays and imaging tests
- Hospital stays (depending on whether the hospital is in **network**)
- Laboratory tests
- Prescription medicines (level of coverage will depend on whether the medicine is on the list of approved medicines)
- Mental and behavioral health treatment
- Diabetes supplies, such as test strips, lancets, and blood sugar monitors
- Medical equipment, such as wheelchairs
- Emergency and urgent care services
- Substance abuse treatment
- Physical therapy and rehabilitation services
- Maternity care
- Home health care
- Infertility treatment
- Hospice care
- Care in a skilled nursing facility
- Chiropractic care
- **Wellness programs**

Quick tip

People with diabetes need more than just coverage for doctors' visits and medications. Make sure that your plan covers everything you need to take care of your diabetes.

What are the different ways to get health insurance?

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

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

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

Some people can buy health insurance through the **Health Insurance Marketplace**, also known as the **health exchange**, which is a website set up by the **Affordable Care Act**. Available plans are broken down into 4 **health plan categories**, with some available at a reduced cost if certain requirements are met.

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


JASON M.
Jason has type 2 diabetes

Here's some help!

Would you like to be able to talk with a real human being who can help you—in person? You can find that too! Visit **localhelp.healthcare.gov.** People and groups in your community can help you apply, pick a plan, and enroll—and for free. Most are available to meet in-person.

Quick definitions

Medicaid

A government-run health insurance program for low-income families and children, pregnant women, the elderly, and people with disabilities. Some states have expanded their Medicaid programs to cover all adults below certain income levels. Each state is different. Check with your state to find out about coverage.

Medicare

A federal health insurance program for people aged 65 or older and for certain younger people with disabilities.

For more about Medicare, see page 26.

Why is it important to review your plan regularly?

Once you are insured, be sure to review your plan at least once a year. Many insurance plans change their coverage benefits and premium costs each year. You will be informed about any changes as your renewal date gets closer. Check to make sure that your preferred health care providers are still in your plan and that the premium is still affordable.

You may decide to switch to another plan that works better for you. Each year there is an **open enrollment period** when people can enroll in a health insurance plan or change plans. There are also special enrollment periods that allow people with a life change, such as a job loss or marriage, to enroll in a plan outside the open enrollment period.

What happens if your circumstances change?

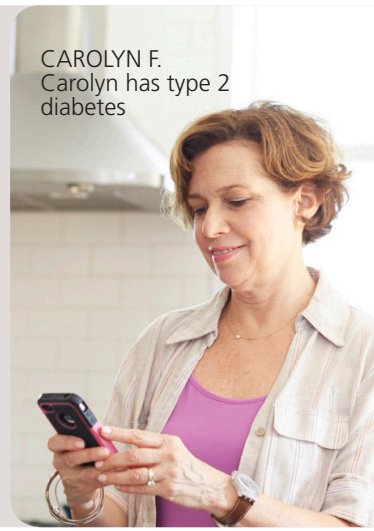
Life is always changing. If the circumstances in your life change, you may have to change your insurance plan as well. For example, if you get married, have a baby, or get health insurance through your job and later lose or change your job, you may have to switch to a different insurance plan, depending on the type of policy that you have. Changing plans because of certain life events is allowed at any time.

Understanding what your plan might cover

To learn more about the services covered by a plan, be sure to read the **summary of benefits and coverage (SBC)** for each plan you are considering. The SBC is a short, easy-to-understand summary of what each plan covers and the associated costs. It can help you compare the benefits and costs of different plans. Every SBC includes an example of what the plan covers for a patient with type 2 diabetes. Everyone's situation is different. For a worksheet that can help you choose a plan, see page 40 of this booklet.

Quick tip

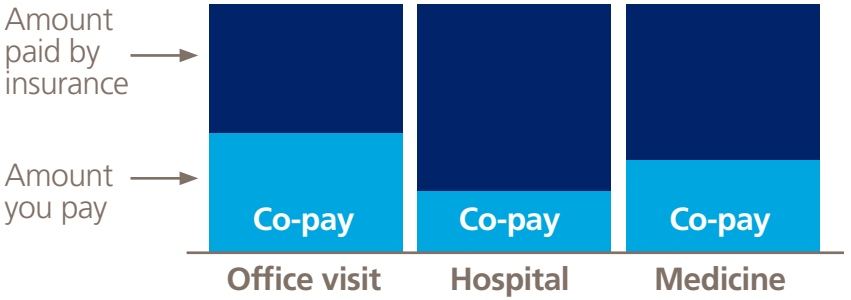
Not really comfortable with the Internet? Talk with someone on the phone! You can call the government's **Marketplace** call center at **1-800-318-2596** to ask a question, start or finish an application, compare plans, or enroll. They're available 24 hours a day, 7 days a week, except certain holidays.



CAROLYN F.
Carolyn has type 2 diabetes

What is a co-payment?

A **co-payment**, or co-pay, is a fixed amount that you pay for a covered health care service, usually when you get the service. The amount can vary by the type of service.

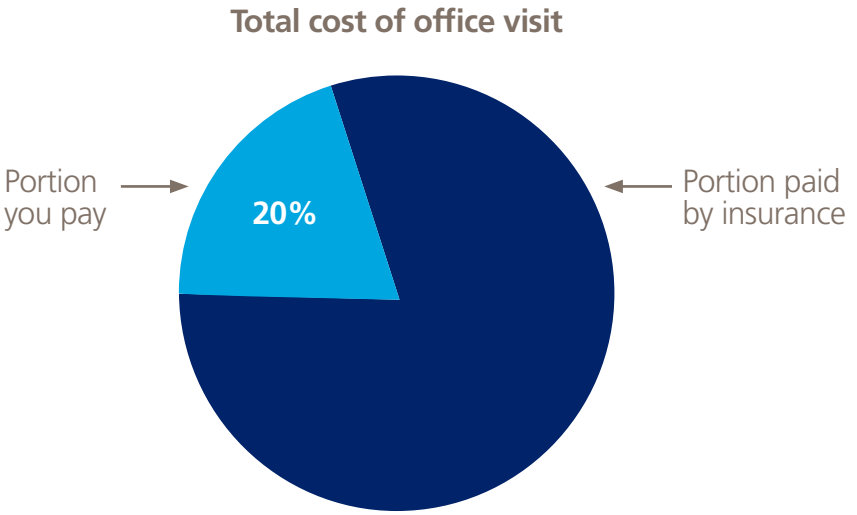


Did you know?

Have you heard of shared decision making? Shared decision making is a process by which patients and their health care providers make health care decisions together, taking into account the best medical information available, as well as the patient's values and choices. When you and your health care provider discuss treatment options, make sure to consider what your insurance will cover.

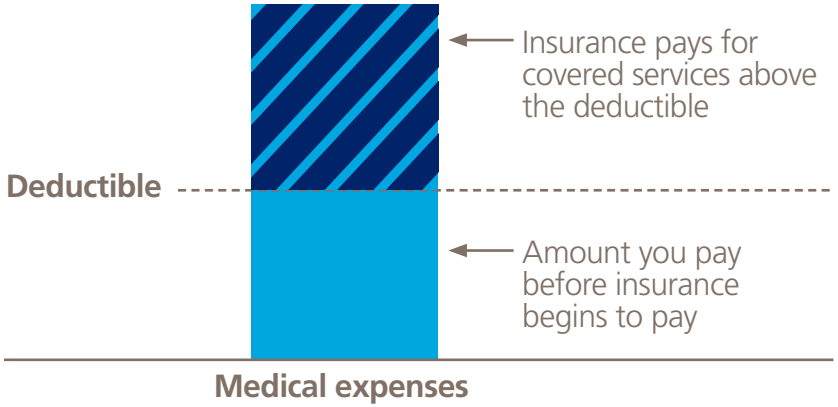
What is coinsurance?

Coinsurance is your share of the cost of a covered health care service. You pay coinsurance after you've met your **deductible**. For example, if the health insurance plan's allowed amount for an office visit is $100 and you've met your deductible, and if you have 20% coinsurance, your payment would be $20. The health insurance plan pays the rest.



What is a deductible?

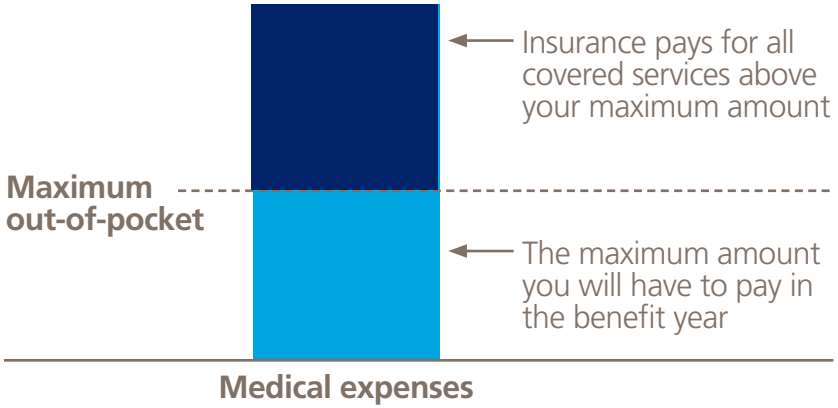
A deductible is the amount you owe for covered health care services before your health insurance plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything (except for **preventive services** and other **excluded services** in the SBC) until you've paid $1,000 for covered services. (Insurance pays for covered services above the deductible, but you may be responsible for a co-pay or coinsurance.)



It's important to find out what is and what is not included in your plan's deductible. Check to see if your medicines and diabetes supplies are included.

What does maximum out-of-pocket mean?

Maximum out-of-pocket is the most you'll have to pay for covered services in a **benefit year**. After you reach this amount, your health plan will pay for all covered essential health benefits from an in-network provider.



What is a high-deductible health plan?

A high-deductible health plan (HDHP) is a plan that has higher deductibles than most insurance plans. HDHPs can be combined with a health savings account (HSA) (see below) to allow you to pay for qualified **out-of-pocket costs** on a pre-tax basis.

What is a health savings account?

An HSA is a type of savings account that allows you to set aside money on a pre-tax basis to pay for qualified medical expenses if you have a "high-deductible" health insurance plan. Combining an HDHP with an HSA allows you to pay for certain medical expenses, like your deductible and co-pay, with untaxed dollars. HDHPs usually have lower monthly premiums than plans with lower deductibles. Unlike a flexible spending account (FSA), HSA funds roll over year to year if you don't spend them. You can take the funds with you if you change jobs or leave the work force. Your HSA may also earn interest.

What is a flexible spending account?

An FSA is an arrangement you set up through your employer to pay for many of your out-of-pocket medical expenses with tax-free dollars. These expenses include insurance co-pays and deductibles, and qualified prescription medicines, insulin, and medical devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. You don't have to pay taxes on this money. Your employer's plan sets a limit on the amount you can put into an FSA each year.

You usually have to use the money in an FSA within the benefit year. But your employer may offer 1 of 2 options:

- It can provide a "grace period" of up to 2½ extra months to use the money in your FSA
- It can allow you to carry over up to $500 a year to use in the following year

Your employer can offer either of these options but not both. And it is not required to offer either.

At the end of the year or grace period, you lose any money left in your FSA. So it's a good idea to plan carefully and not put more money in your FSA than you think you'll spend within a year on things like co-pays, coinsurance, medicines, and other allowed expenses.

What is the difference between preferred and non-preferred providers?

Some insurance plans pay for medical care only when you get it from a provider who is part of the **network plan**.

Providers who are part of a plan are called **preferred providers**

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

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

Review the SBC for each plan to see if your health care providers are part of the network.

How can you find out if a plan covers your prescription medicines?

Health insurance may or may not cover the cost of prescription medicines. Or it may cover only certain medicines.

Whether you have had diabetes for a long time or have just been diagnosed, make sure that the plans you are considering cover your diabetes needs. So when choosing a health insurance plan:

- Check that your diabetes medicines, test strips, and any other medicines that you take are covered
- Find out what the co-pay is for each of your medicines

To find out if a health insurance plan covers your prescription medicines, including your diabetes medicines, you can check the plan's list of prescription medicines (**formulary**). Most health insurance plans have their formularies online. Printed formularies are also available from the health insurance company. If you need help looking up a medicine on a formulary, ask your pharmacist to help you.

Visit the website for your medicines to see if they have a co-pay look-up tool. This will show you how much you will need to pay for your prescription.

Does health insurance cover prescription medicines?

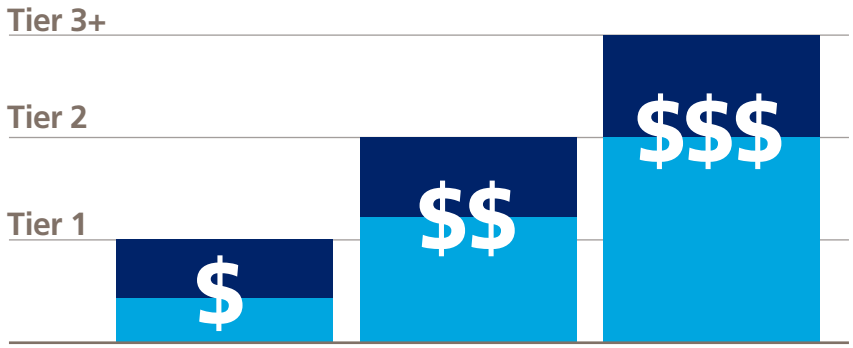
Understanding formularies

Formularies are usually divided into levels, or tiers, depending on the insurance plan. Tiers show how much your co-pay will be, if anything, for a particular medicine. In addition, formularies may have an additional category of "nonformulary." It's important to understand whether you will have to pay a co-pay or a coinsurance amount for your prescription medicines, since this will vary by plan and can change your out-of-pocket costs.

Tier 1. Medicines in tier 1 are the least costly and have the lowest co-pay. These medicines are usually **generic formulations** of **brand-name medicines** (Ask your pharmacist to see whether a **Letter of Necessity** from your health care provider might help you get the medicine you need. Sometimes a form or letter from your provider can help you get coverage for prescription medicines outside of the plan's formulary.)

Tier 2. Medicines in tier 2 are more costly and have a higher co-pay.

Tiers 3, 4, and above. Medicines in tiers 3, 4, and above are the most costly and have the highest co-pay. There may also be a category of nonformulary medicines.



Be sure to find out the details of what medicines are covered and how much co-pay you will have to pay for your medicines before you choose a plan. Medicines may not be included in your deductible. Because formularies are always changing, check your plan's formulary regularly to make sure that it is right for you.

It is also important to know that you may be able to get access to prescription medicines not on your health plan's formulary. Ask your provider about submitting a **prior authorization** request to begin this process. See page 33 for more information about prior authorization.

Something that can help

If you use a Novo Nordisk medicine, you can call the Novo Nordisk Insurance Reimbursement department. A professional may be able to help you regarding your insurance coverage. Please contact them at **1-855-253-2414,** 8:30 AM to 6:00 PM ET, Monday to Friday.

Are there programs to help with the cost of prescription medicines?

If a health insurance plan does not cover a medicine, there may be programs to help people pay for that medicine if they meet certain requirements. These programs are not just for prescription medicines.

- **Government programs**, such as Medicare, Medicaid, and Veterans Affairs (VA) prescription benefits programs
- **Patient assistance programs (PAPs)**: Some pharmaceutical companies provide medicines to qualifying patients at no charge or discounted prices. For more information contact the manufacturer of your medicine.
- **The Partnership for Prescription Assistance (PPA)**, to help eligible people without prescription medicine coverage find a program, which may be a PAP, to help them get their medicines
- **Co-pay savings programs**, sponsored by pharmaceutical companies to provide financial assistance to qualified patients and assist them with their prescription medicine co-pays

Talk with your diabetes care team or pharmacist if you need help paying for your prescription medicines. Your diabetes care team or pharmacist may be able to help you find an assistance program that is right for you.

Something to know

Some pharmaceutical companies offer reimbursement programs to help you get access to your prescription medicines. Look at the websites for these medicines to see what programs are available.

The Novo Nordisk Diabetes Patient Assistance Program provides free medicines to those patients who qualify. For more information about the Novo Nordisk Patient Assistance Program please call **1-866-310-7549**, 8:00 AM - 8:00 PM ET, Monday - Friday or visit **PAP.Cornerstones4care.com**.

Some pharmaceutical companies offer insurance and reimbursement support to help you understand your prescription insurance benefits. If you use a Novo Nordisk medicine, you can call the **Novo Nordisk Insurance Reimbursement help line.** They can help with co-pay information and investigate your benefits to find out whether your provider might have prior authorization or other coverage requirements. Please contact them at **1-855-253-2414,** 8:30 AM to 6:00 PM ET, Monday to Friday.

The **Novo Nordisk Instant Savings Card** programs may make treatment more affordable for eligible patients through ongoing co-pay savings for some products. For more information about the program, Novo Nordisk diabetes products, and eligibility requirements, visit **Save.Cornerstones4care.com**

Understanding Medicare

Medicare is the US government health insurance program for people aged 65 years or older. People younger than age 65 with certain disabilities or permanent kidney failure may also qualify for Medicare. Medicare has 4 parts: A, B, C, and D.

What is Medicare Part A?

Medicare Part A is hospital insurance. It helps pay for **inpatient care** in a hospital or skilled nursing facility (after a hospital stay), some home health care, and hospice care.

What is Medicare Part B?

Medicare Part B is medical insurance. It helps pay for services from doctors and other health care providers, hospital outpatient care, home health care, some medical equipment, and some preventive services.

You can learn more about what Medicare covers from the government booklet "Medicare & You" (Publication No. CMS-10050). Go to Medicare.gov. Or call 1-800-MEDICARE (1-800-633-4227).

What is Medicare Part C?

Medicare Part C (Medicare Advantage) is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. People with Medicare Parts A and B can choose to receive all of their health care services through a single provider under Part C. Most Medicare Advantage plans offer **prescription drug coverage**.

What is Medicare Part D?

Medicare Part D is the program that helps pay for prescription medicines for people with Medicare. With Part D, you choose a prescription drug plan run by a private insurance company approved by Medicare.

Most Medicare Advantage plans offer coverage for prescription medicines, so people with a Medicare Advantage plan may get help with their prescriptions through that program.

You are not required to sign up for Part D. It is optional, but if you choose not to sign up for it when you are first eligible, you may have to pay a late-sign-up fee if you decide to choose it in the future.

Each Medicare prescription drug plan is different. They each have their own list of medicines that they cover. (This is called a formulary.) Many plans organize medicines into different "tiers" on their formularies. Medicines in each tier have different costs. For more information on formularies, please see page 22.

For people with diabetes, it's important to know that Medicare drug plans do cover insulin not taken by pump. They can also cover diabetes supplies, like syringes, needles, gauze, and alcohol pads.

If you have Medicare Part D, you may qualify for Medicare's **Extra Help**, also known as **low income subsidy (LIS)**. This program offers those with limited resources help with paying for medicines and avoiding the **donut hole** (see below).

Did you know?

The donut hole is the coverage gap that most Medicare drug plans have. This gap means that after you and your drug plan have paid a certain amount for covered medicines, you are responsible for paying a percentage of the plan's cost for your medicines. That percentage changes from year to year. Because of the Affordable Care Act, the gap will not exist after 2020.

Quick tip

When choosing a Part D plan, make sure that the plan formulary includes:

- All medicines you are now taking
- The supplies you use
- The pharmacy you prefer

HARMINDER C.
Harminder has type 2 diabetes

What you may need to consider when choosing health insurance

There are many things to consider when choosing a health insurance plan. The most important thing is that the plan should meet your coverage needs and also be affordable.

For people with diabetes, a good plan is one that provides coverage for test strips and other diabetes supplies. It also should provide coverage for services from a diabetes educator, a registered dietitian, an eye care specialist, and a podiatrist. Keep in mind that the plan with the lowest monthly costs may not turn out to be the least expensive in the long run.

Take the time to check over each policy that you are considering to make sure that it meets your needs. Look to see if there are any limitations in coverage. For example, do the plans cover prescription medicines? Keep in mind that many plans do not. Coverage for prescription medicines may be very important.

Everyone has a unique situation. Think about all aspects of your coverage, and consider all the costs that you and your family might have. For example, monthly payments on some plans may be lower, but out-of-pocket costs, such as deductibles, co-pays, and coinsurance, may be higher.

Tips to make your health insurance plan work for you

Explore all of your health insurance coverage options.
There are many different types of health insurance plans. The more information you have, the better your decisions will be.

Review the benefits offered by each plan.
Make sure that the benefits match your medical needs and then choose the one that is best for you. If you are already enrolled in a plan, but it no longer meets your needs, find out when you can change to another plan.

Learn your plan's rules about preauthorization.
Find out if you need to have any medical services, such as surgery, authorized by the plan beforehand. If preauthorization before a medical procedure is required and you have the procedure done without having it authorized, your plan may not cover it and you may have to pay the entire cost.

Use your health insurance plan.
Use your plan to help cover medical costs for services, such as going for checkups, filling prescriptions, and getting emergency care. Using your benefits may help you stay healthy.

Learn how to file an appeal if coverage is denied.
If you are denied coverage for a service that you think is covered by your plan, you may be able to file an appeal. Check your policy to find out how to file an appeal.

Talk with your provider's office staff.
They understand health insurance and will be able to provide advice.

Find out about prior authorizations needed.
A prior authorization is a request submitted by your health care provider to your health insurance company to support your need for a specific prescription medicine. Ask your health care provider if they will provide your insurance company with the information required for a prior authorization if your medicine is not covered. This may help provide you with access to the medicines you need.

Quick tip

Learning about health insurance can help you take a more active role in your own medical care.

What questions should you ask?

Here are some questions to ask yourself when deciding which health insurance plan is right for you.

❑ **Do you want basic or comprehensive coverage?**

A basic plan covers less than a comprehensive plan and usually has a lower monthly premium. A comprehensive plan that covers more services than a basic plan may be better for people with diabetes.

❑ **Does the plan have its own network of health care providers?**

This would include providers who are covered by the plan.

❑ **Is the plan a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), and which do you prefer?**

An HMO often limits coverage to care from doctors who belong to the HMO network and will not cover out-of-network care except in an emergency. **Referrals** to see specialists are usually required. A PPO provides a larger pool of participating doctors and hospitals and allows you to see non-preferred providers if you choose, although you will have to pay more.

❑ **Do health care providers in your area participate in the plan's network?**

- [ ] **Are your current health care providers, including your diabetes care team, part of the plan's network?**

- [ ] **How much will your in-network co-payment be for services, such as medical visits, emergency services, and prescription medicines, within your network plan?**

- [ ] **Does the plan provide any coverage for non-preferred providers?**

- [ ] **Is the out-of-network co-payment higher if you go to a health care provider outside of your network plan?**

- [ ] **Do you need a referral from your primary care physician (PCP) to see a specialist?**

- [ ] **Is your local hospital covered by the plan?**

- [ ] **Does the plan cover services that you need or are important to you?**

- [ ] **Is your pharmacy covered by the plan?**

- [ ] **Does the plan cover prescription medicines, including your diabetes medicines and supplies, such as test strips?**

- [ ] **Does the plan cover your family?**

- [ ] **Does the plan cover your medical costs if you need care while you are traveling or are away from home?**

- [ ] **Does the plan require you to choose a PCP to manage your medical care?**

- [ ] **How much is the plan's premium (monthly cost)?**

- [ ] **How much is the deductible that you will have to pay each year before the plan's benefits kick in?**

- [ ] **Is there a cap, or limit, on the dollar amount of benefits your insurance company will pay in a year?**

Health insurance comparison worksheet

If you're trying to decide on the health insurance plan that's best for you, this worksheet will help you compare options. Use the information provided by each insurance company to fill in the worksheet. When you're finished, take a look at all the information you've filled in to make the best decision for yourself. Please keep in mind that you may need to meet your deductible before these costs apply. For more information on deductibles, please see page 16.

Option 1
Company Name: _____
Phone Number: _____

Option 2
Company Name: _____
Phone Number: _____

Option 3
Company Name: _____
Phone Number: _____

Section 1
Health insurance plan/policy costs

	Example	Option 1	Option 2	Option 3
	ABC Health			
Monthly premium amount	$ 800 per month x 12 months = $ 9600	$_____ per month x 12 months = $_____	$_____ per month x 12 months = $_____	$_____ per month x 12 months = $_____
General office visit co-pay/ coinsurance	$ 50 per visit x 6 visits = $ 300	$_____ per visit x _____ visits = $_____	$_____ per visit x _____ visits = $_____	$_____ per visit x _____ visits = $_____
Hospital visits co-pay/coinsurance	$ 100 per visit x 2 visits = $ 200	$_____ per visit x _____ visits = $_____	$_____ per visit x _____ visits = $_____	$_____ per visit x _____ visits = $_____
Specialists co-pay/coinsurance	$ 75 per visit x 2 visits = $ 150	$_____ per visit x _____ visits = $_____	$_____ per visit x _____ visits = $_____	$_____ per visit x _____ visits = $_____
Dental co-pay/coinsurance	$ 0 per visit x _____ visits = $ Not covered	$_____ per visit x _____ visits = $_____	$_____ per visit x _____ visits = $_____	$_____ per visit x _____ visits = $_____
Total estimated costs on co-pay/coinsurance (Add up your estimate for each in this section.)	$ 10,250	$_____	$_____	$_____

Cost of prescription medicines and diabetes supplies

Is the cost of prescription medicines covered?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, what is the yearly prescription cost? (Could be co-pay/coinsurance)	$ 50 per prescription X 5 number of prescriptions filled = $ 250 x 12 months = $ 3,000	$_____ per prescription X _____ number of prescriptions filled = $_____ x 12 months = $_____	$_____ per prescription X _____ number of prescriptions filled = $_____ x 12 months = $_____	$_____ per prescription X _____ number of prescriptions filled = $_____ x 12 months = $_____

Does the plan/policy cover the prescriptions you need?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does the plan/policy cover the cost of diabetes supplies (for injections, testing, etc)?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
My estimated yearly prescription costs	$ 3,000	$_____	$_____	$_____

Eye care

Total yearly estimated costs for eye care	$ 50 per visit X 2 visits Out-of-pocket costs $ 150 lenses $ 100 frame	$_____ per visit X _____ visits Out-of-pocket costs $_____ lenses $_____ frames	$_____ per visit X _____ visits Out-of-pocket costs $_____ lenses $_____ frames	$_____ per visit X _____ visits Out-of-pocket costs $_____ lenses $_____ frames
My estimated yearly eye care costs	$ 350	$_____	$_____	$_____
Total estimated yearly health care costs (Add up boxes to calculate the total out-of-pocket costs for each option)	$ 13,600	$_____	$_____	$_____

Annual deductibles

Many plans come with a deductible that you may need to meet. This example assumes you've met your deductible. Remember to include the cost of the deductible as you look at each plan.

Is there an annual deductible to meet before benefits take effect?	$ 2,000	$_____	$_____	$_____
Is there a separate annual deductible for prescriptions?	$ 300	$_____	$_____	$_____
My estimated yearly deductible costs (add all lines above)	$ 2,300	$_____	$_____	$_____
What is the yearly out-of-pocket limit? Does it include the deductible?	$ 5,000 ☒ Yes ☐ No	$_____ ☐ Yes ☐ No	$_____ ☐ Yes ☐ No	$_____ ☐ Yes ☐ No

Section 2
Accessing medical services

Do I have to complete a health questionnaire to get the insurance?	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do all my providers accept this insurance?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are all my providers in network?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do I need referrals for specialists?	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do I need preauthorization for medical procedures?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this insurance accept the provider's billing?	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If No, do I have to pay at time of service and get the insurance company to reimburse me?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section 3
Coverage

What services does the plan/policy cover (for example, emergency services, hospitalization, laboratory services, prescription medicines, **eye care coverage**, dental care)?	*Emergency care, hospitalization, prescription medicines, eye care*			
Are any treatments or care excluded?	☒ Yes ☐ No *Dental*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
How are covered services paid for (must I first meet a deductible, which services apply to the deductible, which services require me to pay a co-pay or coinsurance)?				

Something to remember

Be sure to review your plan at least once a year. Many insurance plans change their coverage benefits and premium costs each year. Also, check to make sure that your preferred health care providers are still in your plan and that the premium is still affordable.

DAVID W. AND PATRICIA W.
Patricia's husband David has type 2 diabetes

Section 4
Preferred option (Notes)

Option 1

Option 2

Option 3

Some important words for you to know

Glossary

A

Affordable Care Act

The health care reform law, enacted in 2010, was designed to expand health insurance coverage for millions of Americans.

B

Benefit year

A year of benefits coverage under an individual insurance plan. The benefit year usually begins on January 1 of each year and ends on December 31 of the same year.

Benefits

The health care services or items covered by a health insurance plan.

Brand-name medicines

A prescription medicine sold by a drug company under a specific name or trademark and that is protected by a patent. Brand-name medicines usually cost more than generic formulations.

C

COBRA

A federal law that may allow you to keep your health coverage for a while after you leave your job. With COBRA, you pay all of the premiums, including the amount paid by your former employer.

Coinsurance

Your share of the cost of a covered medical service. Coinsurance is usually a percentage of the allowed cost of service (for example, 20% of the cost of a prescription medicine).

Co-payment (co-pay)

A set amount (flat fee) that you pay for a covered medical service. It is usually paid when you receive the service. The amount can vary.

D

Deductible

The amount you pay for covered health care services before your insurance plan starts to pay. For example, with a $2,000 deductible, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a co-pay or coinsurance for covered services. Your insurer pays the rest.

Donut hole

The coverage gap (the amount you have to pay) in most Medicare Part D prescription drug coverage plans. This means that after you and your drug plan have spent a certain amount of money for covered medicines, you have to pay all costs for your prescriptions, up to a yearly limit. After that, your coverage gap ends, and your drug plan helps pay for covered medicines again.

E

Excluded services

Health care services that your health insurance does not cover.

Extra Help

If you have Medicare Part D, there is a government program that can help you pay for prescription medicines and avoid the donut hole. It is also known as a low income subsidy.

Eye care coverage

A health benefit that at least partially covers eye care, such as eye exams and glasses. All plans sold on the Health Insurance Marketplace include pediatric eye care coverage but do not have to include adult eye care coverage. Check the details of the plans you are considering to see if adult eye care coverage is included. If your plan does not include adult eye care coverage, contact your state's Department of Insurance or a local agent or broker to learn about stand-alone eye care plans that you can buy.

F

Federal poverty level (FPL)

A measure of income level issued each year by the Department of Health and Human Services. The FPL is used to determine your eligibility for certain programs and benefits, such as Medicaid.

Formulary

A list of prescription medicines covered by an insurance plan.

G

Generic formulation

A prescription medicine that has the same active ingredients as a brand-name medicine. Generic medicines often cost less than brand-name medicines.

Group health plan

A health plan offered by an employer or employee organization (for example, a union) that provides health coverage to employees and their families.

H

Health exchanges

Online marketplaces set up by organizations to help with the decisions associated with the purchase of health insurance in each state. See Health Insurance Marketplace and Obamacare.

Health insurance

A contract that requires your insurance company to pay some or all of your health care costs in exchange for a premium.

Health Insurance Marketplace

A state-run or federally run resource where people can learn about their health coverage options, compare health insurance plans, choose a plan, and enroll in coverage. These marketplaces are sometimes referred to as health exchanges or **Obamacare**.

Health Maintenance Organization (HMO)

A type of health insurance plan that often limits coverage to care from doctors who belong to the HMO network. HMOs usually will not cover out-of-network care except in an emergency.

Health plan categories

The 4 types of health plans available from the Health Insurance Marketplace, with each category paying a set percentage of the average overall cost of benefits: Bronze (60%), Silver (70%), Gold (80%), and Platinum (90%).

Hospital outpatient care

Care in a hospital that usually does not require staying overnight.

I

In-network coinsurance

The percentage (for example, 20%) that you pay for a covered health care service to providers who contract with your health insurance plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

In-network co-payment

A set amount (for example, $15) that you pay for a covered health care service to providers who contract with your health insurance plan. In-network co-payments usually cost you less than out-of-network co-payments.

Individual health insurance policy

A health insurance policy that is not a **job-based plan**.

Inpatient care

Health care that you get when you are admitted as an inpatient to a hospital or skilled nursing facility.

J

Job-based health plan

Health coverage that is offered to an employee and the employee's family by an employer.

L

Letter of necessity

A document written to your insurance company or other funding source by your health care provider. The letter provides information needed to convince the insurance company or funding source that the requested health care service or medicine is necessary to meet your medical needs.

Low income subsidy (LIS)

Low income subsidy is a term used for Medicare's Extra Help program. If qualified, the program will help pay for prescription medicines once insurance had paid an allotted amount.

M

Marketplace

See Health Insurance Marketplace.

Medicaid

A government-run health insurance program for people who meet certain income thresholds, including low-income families and children, pregnant women, the elderly, and people with disabilities. Some states have expanded their Medicaid programs to cover all adults below certain income levels.

Medically necessary

Health care services or supplies that are needed to diagnose or treat an illness or injury and that meet accepted standards of medicine.

Medicare

A federal health insurance program for people aged 65 or older and for certain younger people with disabilities.

Medicare Part A

A type of Medicare plan that pays for hospital care. It helps pay for inpatient care in a hospital or skilled nursing facility (after a hospital stay), some home health care, and hospice care.

Medicare Part B

A type of Medicare plan that helps pay for services from doctors and other health care providers, outpatient care, home health care, some medical equipment, and some preventive services.

Medicare Part C (Medicare Advantage)

A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan. Most Medicare Advantage plans offer prescription drug coverage.

Medicare Part D

A program that helps pay for prescription medicines for people with Medicare.

N

NDC Block

A restriction on coverage for prescription medicines. A National Drug Code (NDC) block means that a product is not covered at all. Your doctor may be able to request an exception for you to receive that product.

Network

The doctors, hospitals, pharmacies, and other health care providers that your health insurance plan has contracted with to provide health care services.

Network plan

A health insurance plan that contracts with doctors, hospitals, pharmacies, and other health care providers to provide members of the plan with health care services and supplies at a discounted price.

Non-preferred provider

A health care provider who does not have a contract with your health insurance plan to provide services to you. You will pay more to see a non-preferred provider.

O

Obamacare

An informal name for the Affordable Care Act and for health coverage plans available through the Health Insurance Marketplace. See Affordable Care Act.

Open enrollment period

The period every year when people can enroll in a health insurance plan or change plans. People who get married, have a baby, or lose their coverage for some reason may qualify for enrolling outside the open enrollment period.

Out-of-network coinsurance

The percentage (for example, 40%) that you pay for a covered health care service to providers who do not contract with your health insurance plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network co-payment

A set amount (for example, $30) that you pay for a covered health care service to providers who do not contract with your health insurance plan. Out-of-network co-payments usually cost you more than in-network co-payments.

Out-of-pocket costs

Medical costs that your insurance plan does not pay for and that you are responsible for. Out-of-pocket costs include deductibles, coinsurance, and co-payments for covered services, plus costs for services that aren't covered.

P

Preauthorization

A decision by your health insurance plan that a health care service, treatment plan, prescription drug, or durable medical equipment is **medically necessary**. Sometimes called prior authorization, prior approval, or precertification. Your health insurance plan may require preauthorization for certain services before you receive them, except in an emergency.

Preferred provider

A provider who has a contract with your health insurance plan to provide services to you at a discount.

Preferred provider organization (PPO)

A type of health plan that contracts with doctors and hospitals to form a network of participating providers. You pay less if you use providers that belong to the plan's network. You will pay more for using doctors and hospitals outside the network.

Premium

The cost of your health insurance plan that you and/or your employer pays.

Prescription drug coverage

Health insurance that helps pay for prescription medicines.

Prescription medicines

Medicines that require a prescription by law.

Preventive services

Routine health care that includes screenings, checkups, and patient counseling to prevent illnesses, disease, or other health problems. Most health plans must cover a set of preventive services at no cost to you.

Primary care physician (PCP)

A doctor who is generally the first point of contact for health care. In other words, the PCP is the first health care provider whom you would visit or call when you need care.

Prior authorization

In some instances, health plans require patients to meet specific criteria to receive preapproval before a medicine is prescribed in order for that medicine to be covered under the plan.

R

Referral

A written order from your primary care physician (PCP) for you to see a specialist or get certain medical services. In many health maintenance organizations (HMOs), you need to get a referral before you can get medical care from anyone except your PCP. If you do not get a referral first, the plan may not pay for the services.

S

Self-insured plan

Type of plan often provided by larger companies where the employer, not an insurance company, collects premiums from enrollees and takes on the responsibility of paying employees' medical claims.

Stand-alone dental plan

A type of dental plan offered through the Health Insurance Marketplace that is not part of a health plan. You may want this if your health coverage does not include dental services or if you want different dental coverage.

Subsidized coverage

Health coverage that is obtained with financial help from programs to help people with low and middle incomes.

Summary of benefits and coverage (SBC)

An easy-to-read summary that helps you compare the costs and covered benefits of different health plans. You will get an SBC when you shop for coverage on your own or through your job, renew or change coverage, or request an SBC from the health insurance company.

W

Wellness programs

Programs to improve health and fitness that are usually offered through the workplace or directly by an insurance plan. Wellness programs include diabetes management programs, programs to help you stop smoking, weight-loss programs, and preventive health screening. Wellness programs offer you premium discounts, cash rewards, gym memberships, and other incentives to participate.

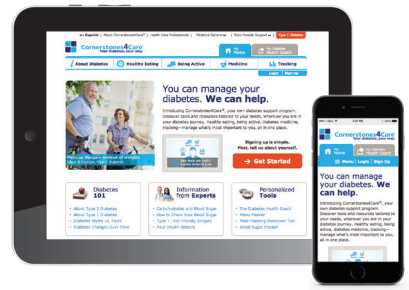
Notes

To learn more…

Health Insurance Marketplace	www.HealthCare.gov 1-888-318-2596
Medicare and Medicaid	1-877-267-2323 www.cms.gov
Novo Nordisk Diabetes Patient Assistance Program (PAP)	1-866-310-7549 PAP.Cornerstones4care.com
Partnership for Prescription Assistance (PPA)	1-888-4PPA-NOW www.pparx.org
US Department of Veterans Affairs (VA)	1-877-222-8387 www.va.gov
Novo Nordisk Diabetes Reimbursement Hotline	1-855-253-2414

Support online

Enjoy the benefits and support of the free **Cornerstones4Care®** program. Simply enroll online at **Cornerstones4Care.com.** You'll be able to take advantage of all sorts of tools for managing your diabetes. Don't miss this chance. **Join today!**



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For more information about Novo Nordisk products for diabetes care, call 1-800-727-6500.

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1 Tell us about yourself

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All fields with asterisks (*) are required.

* ❑ I have diabetes or ❑ I care for someone who has diabetes

* First name _____ MI_____

* Last name _____

* Address 1 _____

Address 2 _____

* City_____

* State_____ * ZIP_____

* Email address _____

Phone number (___|___|___) - |___|___|___| - |___|___|___|___|

Cell phone number (___|___|___) - |___|___|___| - |___|___|___|___|

* Birth date (mm/dd/yyyy)_____

If you are the parent of a child aged 17 years or younger for whom you provide diabetes care, please give the following information for the minor:

First name_____

Last name_____

Birth date (mm/dd/yyyy) _____

2 Tell us a little more

* What type of diabetes do you have? (Check one)
  ❑ Type 2 ❑ Type 1 ❑ Don't know

* What year were you (or the person you care for) diagnosed with diabetes? _____

* What type of diabetes medicine has been prescribed? (Check all that apply)
  ❑ Insulin
  ❑ Diabetes pills (also called *oral antidiabetic drugs*, or *OADs*)
  ❑ GLP-1 medicine
  ❑ None
  ❑ Other

* If you checked "diabetes pills," how many types are taken each day?
  ❑ 1 type of diabetes pill ❑ 2 types of diabetes pills
  ❑ More than 2 types of diabetes pills

* If you checked "Insulin," "GLP-1 medicine," or "Other," please fill in the following for each:

Product 1: _____

How is this product taken? (Check all that apply)
❑ Syringe ❑ Pen ❑ Other delivery system

How long has this product been taken?
❑ Prescribed but not taken ❑ 7-12 months
❑ 0-3 months ❑ 1-3 years
❑ 4-6 months ❑ 3 or more years

How many injections are taken each day?†
❑ 1 ❑ 2 ❑ 3 ❑ More than 3 ❑ N/A

Product 2: _____

How is this product taken? (Check all that apply)
❑ Syringe ❑ Pen ❑ Other delivery system

How long has this product been taken?
❑ Prescribed but not taken ❑ 7-12 months
❑ 0-3 months ❑ 1-3 years
❑ 4-6 months ❑ 3 or more years

How many injections are taken each day?†
❑ 1 ❑ 2 ❑ 3 ❑ More than 3 ❑ N/A

Product 3: _____

How is this product taken? (Check all that apply)
❑ Syringe ❑ Pen ❑ Other delivery system

How long has this product been taken?
❑ Prescribed but not taken ❑ 7-12 months
❑ 0-3 months ❑ 1-3 years
❑ 4-6 months ❑ 3 or more years

How many injections are taken each day?†
❑ 1 ❑ 2 ❑ 3 ❑ More than 3 ❑ N/A

3 Tell us about your interests

Please check up to **2 topics from the list below** so we can offer you the information and support that's most helpful to you.


❑ Healthy eating


❑ Being active


❑ Managing diabetes


❑ Diabetes medicines

4 Review and complete below

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I understand from time to time, Novo Nordisk's Privacy Policy may change, and for the most recent version of the Privacy Policy, please visit www.C4CPrivacy.com.

By signing and dating below, I consent that the information I am providing may be used by Novo Nordisk, its affiliates or vendors to keep me informed about products, patient support services, special offers, or other opportunities that may be of interest to me via mail and email. Novo Nordisk may also combine the information I provide with information about me from third parties to better match these offers with my interests. These materials may contain information that market or advertise Novo Nordisk products, goods, or services.

❑ **Yes, I'd like to be contacted by Novo Nordisk via phone calls and text messages at the phone numbers I have provided.**

By checking this box, and signing and dating below, I authorize Novo Nordisk to use auto-dialers, prerecorded messages, and artificial voice messages to contact me. I understand that these calls and text messages may market or advertise Novo Nordisk products, goods, or services. I understand that I am not required to consent to being contacted by phone or text message as a condition of any purchase of goods or services.

I may opt out at any time by clicking the unsubscribe link within any email I receive, by calling 1.877.744.2579, or by sending a letter with my request to Novo Nordisk Inc., 800 Scudders Mill Road, Plainsboro, New Jersey 08536.

By providing my information to Novo Nordisk and signing and dating below, I certify I am at least eighteen (18) years of age and agree to the terms above.

Signature (required)_____

Date (required) _____
mm/dd/yyyy

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- Staying on track—Blood sugar diary included in back pocket
- Supporting someone with diabetes