

Qualified Health Plan Worksheet

This worksheet is designed to help you organize the information that you will need to make an informed decision in choosing your Qualified Health Plan (QHP). This worksheet emphasizes the possible services individuals with mental health and substance use conditions may want access to.

Your first step is to create an online account and complete an application in the marketplace to see if you are eligible to enroll in a QHP and if you are eligible for any cost-savings measures to make your health care affordable.

Before you start your application make sure you have the following documents available:

- Social Security Numbers (or document numbers for lawful immigrants)
- Employer and income information for every member of your household who needs coverage (for example, from pay stubs or W-2 forms—Wage and Tax Statements)
- Policy numbers for any current health insurance plans covering members of your household

To see if you are eligible for health insurance under a QHP or Medicaid, create an account and fill out an application online at <https://www.healthcare.gov>. You may be directed to your state's individual website.

- To find help with your application in your neighborhood, go to <https://localhelp.healthcare.gov>
- For help over the phone, call 1-800-318-2596. Lines are open 24/7. TTY users should call 1-855-889-4325
- **Important:** If your household files more than one tax return, call the Marketplace Call Center at 1-800-318-2596 before you start an application. (TTY: 1-855-889-4325)

Next Steps

- Review cost-savings measures available to you
- Wait for QHP eligibility letter/e-mail
- Pick multiple QHPs to consider based on your needs
- Call or go on websites of multiple QHPs available to you and fill out the following worksheet for each QHP you are considering.
 - Each QHP you are deemed eligible for will provide you with information on what medications they cover (formulary list) and the doctors, hospitals, etc. that are part of their network. It is up to you to do the research to determine what best fits your needs.
- Enroll in the QHP you have chosen based on your needs and pay your first premium by date indicated



HELPFUL HINTS

The glossary on the last two pages of the worksheet gives definitions and examples of some of the terms used throughout.






The plan with the lowest premiums may not be the most affordable. If you go to the doctor or a specialist often or have a chronic condition, you may want to consider a plan that has a higher premium but lower deductible to reduce how much you have to pay throughout the year.

Mental health and substance use services are considered an Essential Health Benefit, which means that every plan needs to cover some mental health and substance use services, but not all types of services.

Insurers can no longer deny you coverage because of a pre-existing condition (diagnosis of a health problem) or charge higher premiums based on a pre-existing condition.

Information About My Needs

Use this worksheet to organize information about the services you are currently using or would like to use and check if potential QHP cover these services.

	My Needs	Is this covered? Yes <input checked="" type="checkbox"/> or No <input checked="" type="checkbox"/>	
		In-network	Out-of-network
 <p>Name and location of Primary Care Provider</p>			
 <p>Name and location of specialists (For example, psychotherapist, psychiatrist, doctors for other conditions)</p>			
 <p>Name and location of preferred Hospital</p>			
 <p>Other services/ facilities utilized (For example, in-patient program, peer services, alternative treatments)</p>			
 <p>Medications and dosage (Use QHP formulary list to compare what is covered)</p>			

Treatment and Services

What type of services will you want or possibly need? You can find helpful examples and definitions in the glossary on the last page.

	Covered by plan? Yes <input type="checkbox"/> or No <input type="checkbox"/>	Do I need a referral or pre-authorization? Yes <input type="checkbox"/> or No <input type="checkbox"/>	How much is the co-pay or co-insurance?		What are the maximums or limits?
			In-network	Out-of-network	
Primary Care Visits					
Prescription Medicine					
Psychotherapy					
Emergency Room Visits					
Hospitalization					
In-Patient Services					
Intensive Outpatient Services					
Substance Use Treatment					
Home-Based Services					
Rehabilitative Services					
Community-Based Services					
Respite for Care-Takers					
Medical Equipment/ Devices					
Vision					
Dental					

Cost Information

How much will insurance and the services you need cost?

Plan Name (Be specific): _____

Plan Level (Check one): Bronze Silver Gold Platinum

Premium without cost-savings: Annual Amount \$_____ Monthly Amount \$_____

Tax credit or other cost-savings: \$_____

Deductible: \$_____

Co-Pay Costs (Use the table below):

Services	
Primary Care Visit:	\$ _____
Specialty Doctor:	\$ _____
Hospital:	\$ _____
Emergency Room:	\$ _____
Urgent Care:	\$ _____
Prescriptions	
Tier 1 Prescription:	\$ _____
Tier 2 Prescription:	\$ _____
Tier 3 Prescription:	\$ _____

Co-Insurance: \$_____

Out-of-pocket maximum per year: Individual \$_____ Family \$_____

Cost reduction to out-of-pocket maximum (Silver plans only): \$_____

Other costs to consider: _____

Additional cost-saving health options (Ex. Discounts on gym membership, massages, etc.):

Glossary

Co-insurance- Your share of costs for a service. This is a percentage of the total cost for a certain service.

Community-Based Services – A wide array of services that are delivered in the community and not in a hospital or doctor’s office. Community based services support recovery and enable inclusion.

Co-payment (Co-pay) - A fixed amount you pay for a service, usually paid when you get the service. The amount can vary by the type of service. For instance, you may have one co-payment amount for visiting your primary care doctor, and a different co-payment amount for specialist or Emergency Room visits.

Cost Sharing Reduction- A discount that lowers the amount you have to pay out-of-pocket for deductibles, coinsurance, and copayments.

Deductible – This is the amount of money you have to pay out of pocket before your insurance plan pays anything. Not all services require you meet the deductible before the insurance plan pays.

Essential Health Benefits – A set of health care services that plans must provide to be a certified QHP.

Formulary – A list of prescription drugs that a specific plan will cover.

Health Maintenance Organization (HMO) - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won’t cover out-of-network care except in an emergency. An HMO may require people who use its plan to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Home-Based Services - These are services that are provided in your home and can range from family therapy delivered in the home to home health aides who assist people with medical conditions with their daily living needs.

Inpatient Services - Health care that you get when you’re admitted to a health care facility, like a hospital or skilled nursing facility. For behavioral health needs, these services are usually short-term hospitalizations for individuals in need of a safe, secure and therapeutic environment.

Integrated Care – Coordination of all of your health needs by one facility or one provider.

Intensive Outpatient Services (IOP) - The typical IOP program offers group and individual services of 10–12 hours a week. IOP allows the individual to be able to participate in their daily affairs, such as work, and then participate in treatment at an appropriate facility in the morning or at the end of the day. An example of this would be going to group therapy, individual therapy, and having your medication managed all in the same facility that you visit daily or a few times a week to assist in recovery of a substance use condition.

Medical Equipment/Device - A medical device is an instrument, apparatus, implant or similar item that is used to diagnose, prevent, or treat disease or other conditions.

Network - The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Qualified Health Plan (QHP)- An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.

Premium - The amount that must be paid for the consumer’s health insurance or plan. The consumer and/or their employer usually pay it monthly, quarterly or yearly.

Point-of-Service (POS) - A type of insurance plan in which the consumer pays less if they use doctors, hospitals, and other health care providers that belong to the plan's network. With this type of plan, a consumer may go to out-of-network providers, but at a higher cost. POS plans also require the consumer to get a referral from his or her primary care provider in order to see a specialist.

Preferred Provider Organizations (PPO) - A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. The consumer pays less if he or she uses providers that belong to the plan's network. The consumer can use doctors, hospitals and providers outside of the network for an additional cost. Most of the time a referral from a primary care provider is not needed in order to see a specialist with a PPO insurance plan.

Primary Care Provider - Physician that you go to regularly for check-ups and helps coordinate a range of health care services. This can be a doctor, nurse practitioner, clinical nurse specialist or physician assistant.

Psychotherapy – Therapeutic interaction or treatment between a trained mental health professional and a client, family, or group.

Referral - A written order from your primary care doctor for you to see a specialist or get certain medical services. For HMOs, you need one of these before you see a specialist or your plan may not pay for the service.

Rehabilitation Services – These services focus on helping individuals develop skills and access resources needed to increase their ability to be successful and satisfied in the living, working, learning and social environments of their choice.

Respite for Care-Takers - Respite programs provide planned short-term and time-limited breaks for families and other unpaid care givers.

Specialist- A doctor or other health care provider who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. For example, a cardiologist is a heart specialist, a dermatologist is a skin specialist and a psychiatrist is a mental health specialist.

Tiers used for Prescription Benefit - Some QHPs will be using tiers to determine the "value" of a medication. Value is decided by the QHP by taking into consideration effectiveness and cost. Tier 1 will have the lowest costs with the highest "value"; Tier 2 will be higher cost with lower "value"; and Tier 3 will be highest cost with lowest "value".