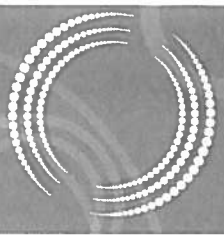
The Affordable Care Act and Individuals with Diabetes



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Essential Health Benefits

Starting in 2014, a minimum set of "essential health benefits" such as hospitalizations, prescription drugs, preventive services, and chronic disease management must be covered in all new individual and small group plans, including all plans sold in the new Health Insurance Marketplace (see reverse).

No Annual Dollar Limits on Essential Health Benefits. Most health plans cannot set a dollar limit on what they spend on "essential health benefits" for an individual's care during a given year.

Free Preventive Care

The following diabetes treatments are covered under the Affordable Care Act:

- Diabetes screenings for adults with high blood pressure
- Diabetes screenings for pregnant women
- Medical nutrition therapy for people with diabetes*
- An annual wellness visit to develop (or update) a personal prevention plan for Medicare participants

**This will vary from state-to-state. See your state specific plan for a complete list of services offered*

Coverage for Patients with Diabetes

Starting in 2014 job-based plans and new individual plans aren't allowed to deny coverage, charge more, or refuse to cover treatments due to a pre-existing condition such as diabetes.

Young Adults

Young adults can stay on their parent's insurance plan until age 26 as long as the policy covers dependents.

Children

Job-based plans and new individual plans cannot deny children coverage because of diabetes or any other pre-existing condition.

Diabetes Self-Management Training

DSMT is not considered a 'free' preventive benefit, so patients will still have a copay. DSMT is not specifically mentioned, but is clearly part of the mainstream treatment regimen for diabetes, so we believe it will be covered in virtually all Marketplaces. However, states have the discretion to modify benefits within categories, or to put limits on certain benefits, such as the number of visits allowed.

Limits

Plans can set a limit on benefits, such as number of doctor visits, number of prescription drugs, or days in the hospital. However, **there is no lifetime dollar limit on coverage.**

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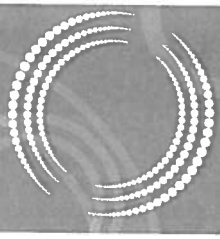

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Marketplace Insurance Plans

Platinum
Enrollee pays 10% of healthcare costs
Lower out of pocket, higher monthly premium

Gold
Enrollee pays 20% of healthcare costs

Silver
Enrollee pays 30% of healthcare costs

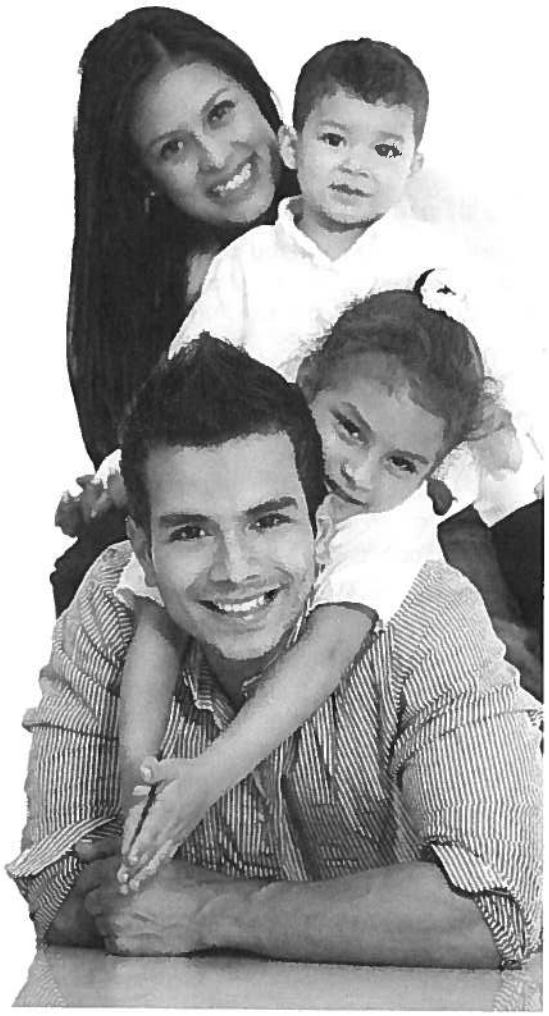
Bronze
Enrollee pays 40% of healthcare costs
Higher out of pocket, lower monthly premium

Plans can only set higher premiums based on the following:
- Age
- Tobacco use
- Family size
- Geography

Health Insurance Marketplace

A Health Insurance Marketplace is a new way for individuals, families, and small businesses to shop for various private health insurance plans all in one place. Plans offered in the marketplace must meet certain requirements for benefits, consumer protections, and cost to the consumer. Individuals can check their eligibility for premium or cost-sharing help at www.healthcare.gov. Open enrollment for 2014 begins October 1, 2013 and ends on March 31, 2014.

Marketplace plans are separated into the following categories: Bronze, Silver, Gold and Platinum. Plans differentiate based on the percentage the plan pays for covered benefits. For example, individuals with a Bronze health plan will pay the most each time for doctor's office visits and medicine but will pay the smallest premium each month. With a platinum plan, individuals pay the least for doctor's office visits or medicine but will pay the highest premium each month.

Important Facts

- Starting in 2014, most individuals must have health insurance that meets certain standards or they pay a tax penalty in the following year, unless they qualify for an exemption. Plans purchased in the Marketplace, job-based coverage, Medicare, Medicaid, Children's Health Insurance Program (CHIP), Military Health Care System (TRICARE) and the Veterans Health Care Program are considered 'approved' plans that meet this standard.
- Benefits with mandatory coverage include: doctor's office visits, emergency room services and hospitalization, pregnancy and newborn care, mental health and substance abuse disorder services, laboratory services, preventive services, chronic disease management, and children's health services (including oral and vision care).
- Individuals may still buy health insurance directly from an insurance company outside the Marketplace, but those plans are not eligible for financial assistance. Although all insurance plans sold inside and outside the Marketplace are required to meet the criteria specified in the Affordable Care Act, plans sold outside of the Marketplace are not subject to the same credentialing regulations as those sold inside the Marketplace and monthly premium rates may be less predictable.
- Patients are encouraged to ask a Health Insurance Marketplace Navigator for a "Summary of Benefits and Coverage" that will include a general overview of diabetes treatment for each health plan under consideration.