Navigating Insurance:

Hot Topics During Cancer

National Webinar Transcript

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I. Introduction

Bonnie Beckoff: Good evening, everyone. I would like to welcome all those who are listening from all across the country and thank you for joining us this evening for Sharsheret's national webinar on Navigating Insurance: Hot Topics During Cancer.

My name is Bonnie Beckoff and I'm the Senior Support Program Coordinator at Sharsheret.

Throughout the webinar, feel free to ask any questions by typing in the question box on your dashboard on the right hand side of the screen. Please keep your questions broad in nature so that everyone on the call can benefit from the discussion. We will try to get to as many questions as we can after the presentation. For those of you, who are not joining us via computer, please know that you can call Sharsheret at any time with your questions and we will be happy to discuss them with you.

I would like to begin by thanking our sponsors who, without their generous support for tonight's program, would not be possible. Thank you. Daiichi Sankyo, Amgen, MacroGenics, and The Siegmund and Edith Blumenthal Memorial Fund and our partners at Triage Cancer.

For those of you who are not familiar with Sharsheret, Sharsheret is the Hebrew name for chain, and we are a national, not-for-profit organization supporting young women - and their families - of all Jewish backgrounds - who are facing breast and ovarian cancer at every stage. Our mission is to improve the lives of Jewish women and families living with, or at increased genetic risk, for breast or ovarian cancer through personalized support; and save lives through educational outreach. While our expertise is in young Jewish families as related to breast cancer and ovarian cancer, Sharsheret programs serve all women and men. Our goal is to connect to our community whatever your personal background, stage of life, genetic risk, diagnosis, or treatment.

As women are coping with illness, they are increasingly concerned about insurance coverage, financial planning, and general issues of financial and legal wellness. As with all of Sharsheret's programs, we begin with our callers. Every day we're hearing about your financial concerns and we are determined to respond to your needs. Recently we launched a new program called Best Face Forward 2.0 which provides services and subsidies for eligible individuals for non-medical services that are critical to a woman's quality of life and body image, and that are only partly covered by insurance companies, if at all. Best Face Forward 2.0 services include financial subsidies for wigs (cranial hair prosthesis), cold caps (scalp cooling treatment), and tattooing (three-dimensional micropigmentation of the nipple and areola). Additionally there are complementary and holistic offerings such as meditation and yoga. For more information please reach out to our clinicians at 866-474-2774 who will be happy to answer all your questions.

As we all know, surgery and treatments can be very expensive, and insurance options greatly affect the impact of this financial strain. Just last week, a study from the Dr. Susan Love Research Foundation and the Sisters Network was published about the influences of treatment costs on breast cancer surgery preferences. The study showed that 43% of women considered costs when making a decision about treatment and breast cancer surgery and 23% of the women reported that the cost of the treatment heavily determined what type of surgery they were going to have, 29% of lower income families did not have necessary medical testing. Additionally, according to the survey, even women with a higher financial income reported that cost was extremely important to them and women in all financial brackets reported that breast cancer treatments depleted their savings.

At the same time, research suggests the financial toll of a diagnosis may impact your health. A 2016 study conducted at the Fred Hutchinson Cancer Research Center in Seattle found that the financial toxicity resulting from the high cost of cancer is almost as deadly as cancer itself. The study speaks about the possible need for time off from work that can cause a loss of wages, or loss of insurance, which can in turn cause one to have to pay out of pocket. These financial and insurance concerns, can all increase ones stress level and cause the healing process to take longer. To help our community address these concerns, tonight's discussion led by insurance expert, lawyer, and patient advocate Monica Bryant from Triage Cancer will discuss important topics such as navigating your insurance, clinical trials, new research and new treatments - and how they interface with insurance, how to Pick a Plan, understanding your EOB, Step Therapy, and Access Barriers which will shed light on the financial difficulties caused by cancer - and how to help mitigate some of it by properly knowing and understanding your insurance and choices. We will also hear a personal story from a woman who had to learn the hard way how to navigate insurance and what that experience has taught her. After the presentations, we will have an opportunity for you to ask your questions. Our goal this evening is to establish an informative dialogue between our experts and those of you who may have questions about your insurance throughout your cancer experience.

So with that, I would like to introduce Monica Bryant. Monica is a cancer rights attorney, speaker, and author, dedicated to improving access to, and availability of, quality information on healthcare-related issues. Monica is the co-founder and Chief Operating Officer for Triage Cancer, a national non-profit organization that provides education on the practical and legal issues that may impact individuals diagnosed with cancer and their caregivers. Monica has spent many years working on behalf of individuals with cancer and has presented hundreds of educational seminars throughout the country for patients, survivors, caregivers, healthcare Professionals, advocates, lawyers, employers and the general public. We are privileged to have her here with us this evening.

Monica, I will go ahead and work the slides for you, if you just tell me when to move on to the next slide.

II. Navigating Insurance

Monica Bryant: Thanks so much for having me to here tonight to talk a little bit about insurance and navigating the process of dealing with insurance and clinical trials. Given that we have a limited amount of time today. I just want to tell you a little bit about triage cancer, and the services that we provide, so that after today's webinar you have somewhere to go for more resources. So as was mentioned triage cancer is a national nonprofit organization that provides education on the Practical and legal issues that may impact individuals who are diagnosed with cancer and their caregivers, and we provide this education in several different ways, we participate in events all over the country and at the end of this year. We will have been in all 50 states and one of the main events. I wanted to mention our triage cancer conferences, and these are an opportunity for people to come together. So, individuals diagnosed, survivor's caregivers, their Healthcare Professionals, lawyers, and learn about the most common topics that can impact somebody's finances including health insurance . We also host monthly webinars that are open to anybody in the community on a variety of legal and practical issues. The next one is actually this week on hospice care, and we also record our past webinars. So there are a couple of times throughout today's presentation, I am going to point you back to a past webinar where you can go and listen to this entire topic again in detail.

In addition to our events, we offer a number of educational materials and resources online and we refer to these as our quick guides. They are downloadable for free, and you'll see links in today's presentations, but we know that it can be hard to digest all of this information all at once - and so these quick guides are a snapshot of a particular topic and we also have checklists and other documents to really help with the legal and practical pieces of cancer survivorship Now the reality is, where you live can impact what protections you have access to - so we have charts of state laws on employment disability health insurance and other cancer related issues today. I'm going to talk about some federal protections, but keep in mind that the state laws may actually provide you with additional or better protections so critical to look there as well. Now, we know that people learn in different ways. So we also have animated videos on cancer survivorship topics and there's one specifically about health insurance basics and how to pick a plan. So again, after today, if you're thinking: - wow, I really wish I could hear that again. Please feel to check out our animated videos and then throughout the many, many years of doing this - people would often say: I wish as I was making these decisions that I could just have you in my pocket, or I could just sit down and talk to you; and while I'm happy to do that to the extent that I can - you know, there's only a couple of us - and so what we did instead was create cancer finances.org and this website provides practical information on the topics that can impact your finances. It's designed to guide users

to the information that's most relevant to their situation. So it's sort of a Choose Your Own Adventure type website. So with that as background as additional places, in addition to Sharsheret where you can go to get some information.

I want to get to the heart of the topic today, which is health insurance now, the reality is that health insurance is confusing but to get the most out of your plan. There are some Basics that are really useful to know. There's three main places where we get health insurance in this country. The fewest number of Americans get their insurance directly from a health insurance company. The next largest group get their insurance through the government primarily through Medicare or Medicaid and the military, and then the largest group of Americans get their insurance from an employer. But many of us, regardless of where we get our insurance don't understand even the terms that are being used. We often joke that there should be a class in high school that teaches us about health insurance because we all need to use it, but yet none of us are really taught how to so starting at the top. There are some costs that you will incur just to have health insurance coverage, and that's called your premium. It's what you pay each month just to have coverage. So you're going to pay them even if you never go to the doctor.

Then there are going to be some additional costs that you pay when you actually get medical care, and these are going to differ depending on your policy. So first, is your annual deductible. This is the amount that you have to pay out of pocket - each year - before your health insurance policy kicks in. This fixed dollar amount could be anywhere from $0 to $7,000, all depending on the plan. Next is your co-payment. This is also a fixed dollar amount, and it's a payment that you pay when you get certain types of care.

For example, many policies have a co-payment of $20 when you see the doctor or a $250 co-payment if you go to the emergency room. And then all plans are also going to have a coinsurance or a cost share and these are two terms that mean exactly the same thing and it's the difference in what the insurance company pays for your medical care and what you pay so you're literally sharing the cost. For example, if you have an 80/20 plan, then the insurance company is going to pay eighty percent of your medical expenses and you're responsible for twenty percent of your medical expenses. Once you've met the deductible.

And finally there's your out-of-pocket maximum; and this may be one of the most important things to understand about your health coverage. Again, this is going to be a fixed dollar amount that's going to depend on your policy; with the way you get to your out-of-pocket maximum is by paying your deductible plus any co-payments that you make during the year plus any coinsurance that you make so it's everything that you pay except your monthly premiums. Now, to reach that out-of-pocket maximum, your insurance pays one hundred percent of your medical expenses and you don't pay anything for the rest of the year, except your premiums. So by understanding how your out-of-pocket maximum works

you can plan around what your costs might be in the worst case scenario and hopefully avoid financial ruin after a serious medical situation.

So when you're thinking about these out-of-pocket maximums remember that insurance companies usually are only going to count expenses that are from in network providers. So to give you an example of how this out-of-pocket maximum works, I'd like you to meet David. David was in a car accident and spent a week in the hospital that is in his policy's network. He ends up with a $102,000 hospital bill. So how much does he actually have to pay? David's plan has a two thousand dollar deductible and 80/20 coinsurance and a $4,000 out-of-pocket maximum . So how much does he end up having to pay of that total $102,000 hospital bill? [next] First, he has to pay his deductible of $2,000 which leaves a $100,000 of that bill left. Next then he has a 20% coinsurance. Well 20% of $100,000 is $20,000. But does he have to pay that whole $20,000 next? No, he doesn't - his out-of-pocket maximum is $4,000. So, since he's already paid $2,000 of his deductible, he only has to pay another $2,000 to reach his $4,000 out-of-pocket maximum. So I'm not suggesting that $4,000 isn't a lot of money, but when we compare it with the $20,000 he'd have to pay just of his coinsurance or $102,000. He would have to pay without insurance; It certainly becomes more reasonable.

So again, understanding your out-of-pocket maximum is critical for picking a plan; which we'll get to in just a few more slides. So I want to talk a little bit about prescription drugs. So insurance plans that cover prescription drugs - as most do, generally have a list of drugs that they will cover and they will tell you at what rate they're going to cover those drugs and that list is referred to as a formulary. Formularies are typically going to group their drugs into tiers. And the tier that your medication is in is going to determine how much you're going to pay for that. So typically formularies are going to have somewhere between one to five tiers. The higher up you go in tiers generally the more that you have to pay.

Now many insurance companies also employ something called Step therapy. Step therapy means that you're required to try less expensive drug options at a lower tier before stepping up to drugs that might cost more. So in many instances this might mean that you're required to try a generic drug before you try a brand name drug. Now in some circumstances, it can be really concerning to people that they aren't able to access the exact drug that their provider prescribes but the good news is there are some workarounds or options. If you're in this situation if you've already tried the more affordable drug and it didn't work or if your healthcare provider believes that it's medically necessary for you to be on a more expensive drug, your provider can contact your health insurance company and request an exception.

So an exception request is a type of appeal that your Healthcare team submits on your behalf. Insurance companies have their own forms that need to be submitted. Along with that specific form your Healthcare team is going to need to provide some documentation that step one medications have already been tried or they're likely to cause adverse effects. So in this exception request or appeal situation, it's absolutely a

time when you have to be having conversations with your health care team about your concerns and enlisting their help.

It may also be that you experienced another type of claim denial from your insurance company and the good news is that you don't have to take no for an answer. Generally, you have two chances to appeal a denial of coverage.

There's an internal appeals process and an external appeal. Internal appeal is going to be through your health insurance company. And thanks to the Affordable Care Act or Obamacare or state law, every state is required to have an external process and this is incredibly important because we know that somewhere around 60% of all appeals are decided in favor of the patient. So it's absolutely in your best interest to appeal denials. And we actually have a quick guide on appeals that was released earlier this month . Now as many of you may know the Affordable Care Act also made some changes to the way that insurance is handled in this country and perhaps most significantly it changed the way that insurance companies can treat people with pre-existing conditions [next]. First, it said that insurance companies can only look at four things when they're deciding how much they're going to charge them: 1) Are they buying an individual or a family plan 2) their geographic location 3) their age and 4) their tobacco use. So this takes out pre-existing conditions and gender out of the equation .

The second thing that the ACA did was it said that insurance companies cannot deny selling somebody a policy or refuse to cover care related to a pre-existing condition. So this is incredibly game-changing for our community because the bottom line is that this means you cannot be denied coverage or charged more just because you've gotten sick. This gives us some more options .

Now the time that you have to enroll or make changes to your coverage is going to depend on what type of coverage that you have. So Medicaid applications are accepted year-round. So as soon as you're eligible, you can apply. For plans based on purchase from the individual insurance companies. Generally, you can enroll and make changes during open enrollment. Now open enrollment for this year is closed -but for 2020-ot will start November 1st and go through December 15th.

This is a condensed open enrollment period from previous years. So in states that run their own marketplaces like California, for example open enrollment might last longer. So it's important to check your State's rules. Now Medicare open enrollment is also coming up an employer plans may vary, but generally they all happen in the fall. So this is a prime time for us to be having this conversation about how to choose a plan . The good news though is that the ACA recognizes that changes don't just happen during open enrollment, so they created a special enrollment period where if you have a life-changing event that's going to result in you losing coverage. You have 60 days to shop for a new plan in the marketplace .

Now, I'm going to go through a quick example of how you can go about comparing your plan options. Now, this is going to apply whether you're looking for a Marketplace plan whether you're comparing two employer plans, whether you're trying to decide: do I keep my employer plan or do I take a Marketplace plan or even if you're comparing two Medicare plans . So here I've provided you three different examples of policies. First is a bronze, the second is a silver and the bottom one is a platinum and you can see they all have different expenses. But can you tell just by looking at them which is going to be the most affordable at the end of the year assuming you're going to hit that out-of-pocket maximum. And when we're talking about cancer care the reality is you're probably going to hit that out-of-pocket maximum. Well, I certainly can't tell just by looking at it.

The way you understand which is going to be the most affordable is by doing the math. And here's how you do the math. You take the monthly premium and you multiply it by 12. That's how much it's going to cost you for the year. And then you add the out-of-pocket maximum. When you do this for all three plans, you can see that that bottom Platinum plan that costs 400 dollars a month ends up being close to $2000 cheaper by the end of the year.

It's also important to note that that bottom plan has a zero dollar deductible which means that plan starts picking up 90% of your health care costs right away. Whereas that top bronze plan that appears to be cheaper monthly has a $6,000 deductible. That means you have to write a $6,000 check before the insurance company starts paying a penny. So with this knowledge, we can start making some educated decisions and understanding that we can't get sticker shock. Just looking at that monthly premium that we have to look at the big picture . But of course cost is only part of it. You have to check the networks of doctors and hospitals to make sure that your doctors are covered. You also need to check the prescription drug coverage. So what drugs are covered? Is there a separate deductible? Does it require step therapy for a particular drug that you're taking? All of this information is incredibly important.
And thanks to the ACA and its new protections, we are in a world where we get to review our options every single year and we get to make changes based on where we are right now.

So if somebody's in the midst of active treatment, they may be making different decisions based on the knowledge that they're likely going to hit that out-of-pocket maximum compared with someone who's maybe out of active treatment and isn't accessing as much medical care now as they used to .

Now a brief nod to clinical trials. Clinical trials are incredibly important and they're the main way that we find new and better treatments for coverage. But we have to know what it's going to cost us and part of that includes what your insurance company is going to pay for and what out-of-pocket costs you might have. Now, if you have private insurance through your employer, the Marketplace or a plan that you bought on your own the ACA requires your insurance company to cover any routine costs

associated with participating in that trial. So routine costs are ones that you're going to pay if you were getting standard treatment including visiting the doctor's office getting scans any medications to help with side effects. So it's typically everything except the treatment being tested and that's usually paid for by the clinical trial. Now when it comes to Medicaid it's up to the state. So you should definitely check with your health care team If you're receiving Medicaid . Now Medicare and Military plans also will cover the routine costs, but they all have a little bit of different details. So if you have one of these types of insurance again, very important to talk with your Healthcare team so that you understand the costs .

Now certainly there are some eligibility requirements about participating in clinical trials. But if you're not eligible, you may be able to get a special exception or apply through the FDA expanded access program to access clinical trials . But insurance isn't going to cover all of your costs, even if you have insurance through a Marketplace, so it's important to talk with your team about other sorts of practical costs that may arise and we've listed some questions for you to ask here. And the reality is you might incur these costs whether you're in a clinical trial or not. We just want people to be aware of them so that they can make educated decisions

And then just as a reminder, we recently released an animated video on clinical trials funded by the Metastatic Breast Cancer Alliance where you can hear all of this and more and it points to some additional places to go for resources.

So once you get treatment, regardless of where you get your treatment, you're going to get a couple of pieces of information from the insurance company. You could get three different pieces of mail, but the most important is going to be the explanation of benefits (EOB). Now, you can generally tell that this is the explanation of benefits. You'll see in big bold letters somewhere word saying this is not a bill [next]. You're also going to see some information about the member, who the patient was, and the information about the summary [next. Please click through three times]. And then you're also going to get some information about the services. It is incredibly important to check to make sure that this all looks correct. Now some EOB won't have any words on them. They'll just have a CPT code. So you may need to contact your healthcare provider to get some more information about what you're being billed for.

Now at the bottom here, you'll see that on EOBs, a good EOB- will also have some information about how much you paid towards your deductible and your out-of-pocket maximums. This is also very important to keep track of so that you know how close you are to that out-of-pocket maximum . Now, the last thing that you're going to get is a communication from your provider and that's going to be the bill. The problem is it doesn't always happen in this order. Many providers are faster at sending the bill than the insurance companies are at processing the claim. So if you pay that bill before you get your EOB, you may be in a situation where you're trying to get money back from your provider. So our general rule of thumb

is to wait until you've received your EOB before paying any bills. Now, it's important to communicate with your providers and let them know: “Hey, I haven't gotten my EOB yet and that's why I'm not paying” and most of them will just push back the due date or put a note in your file.

I mentioned reviewing your bills for accuracy and that is incredibly important. We hear stories all the time about mistakes and billing where people have been billed for 11 surgeries instead of one because someone accidentally put you know, the one in twice. If you have extensive bills and you think there are mistakes or you were miss billed, there are Professional bill reviewer services that you can enlist. These are just some examples. We're not endorsing any of these but it could be a good option for some bills .

So today we have just provided an introduction to these topics, and I just want to remind you that Triage Cancer has resources designed to help navigate all of the Practical and legal issues that can come up and impact your finances, and if you go to our resources Tab and do Resources by topic, this is what you'll see and it'll take you to some more information .

So I look forward to your questions later on, but if we don't get to them tonight, please know that we are happy to be available to you and a resource to you in the future. So with that, thank you and I look forward to your questions.

Bonnie Beckoff: Thank you Monica for all that wonderful information. The insurance world can feel a bit overwhelming and confusing and sometimes frustrating and I believe you have armed us all with so much helpful information. Thank you so much. And now it is my pleasure to introduce our peer supporter. Sarah. Sarah has agreed to share her personal story about what she has learned on how to navigate the world of insurance.

III. Personal Story

Sarah: Hi everyone. I'm so glad that I could be here tonight and share a little bit about my story. I hope it will, you know, give a little bit of insight of how hard as many of us know it could be. So just for a little bit of background I guess; I come from a long family history of women who had breast cancer. So it was no surprise when I tested positive for the check two mutation, which is a mutation that increases my risk for breast cancer. After receiving my positive test result. My doctor sent me for a baseline breast MRI. The office where I scheduled the MRI did not accept my insurance but was willing to work with me and submit it to my insurance on my behalf. Luckily at the time, I had a low sorry. I had a low out-of-network deductible and my insurance company paid for my MRI as with 40% of old Baseline MRIs, mine came back with an enhancement that led to a 3D monogram and ultrasounds and an MRI guided biopsy. This entire time my insurance plan covered basically majority and much of my costs. Luckily the biopsy also came back negative. But as a standard of care, I was told to come back six months following for an MRI guided

biopsy and you need to return for a follow-up MRI also six months later. Though when it was time to go through this all again my insurance had changed because my husband had switched employers. Well, I have what's considered to be a good coverage. My out-of-network deductible is very high and the time was completely unnecessary meaning my doctor's office would receive no reimbursement from my insurance company and I to be responsible for 750 dollars a reduced rate. They were offering me 750 for an MRI which was way too much for me. So I decided to look elsewhere.

Unfortunately looking elsewhere essentially meant that I couldn't get around to finding a new location for an entire year. When I finally got my act together to find a new doctor's office, I looked for an office where I trusted the medical care above all and that was in my network with my plan. Looking for doctors that are in network was something I had been trained to do since I was young and the only question I thought I needed to ask. When I got a bill though for $1,300 for my MRI, I realized how big of a mistake I made as soon as I got the bill. My first instinct was to call the insurance company assuming the insurance just wasn't applied correctly. What I found out from my insurance company was that my bill unfortunately was correct. They explained that doing an MRI and an in-network facility associated with a hospital required me to first meet my deductible which was a thousand dollars and then pay 20% of the coinsurance which in this case would have cost an additional 300 had a done the MRI and in an in-network freestanding location not associated with any hospital, it only would have cost me $100 copay.

Unfortunately, the 1,300 dollar MRI required an additional follow-up MRI, but this time I was smarter and I knew that I needed to call my insurance first to request a list of all in in network freestanding Radiology practices in my area. Well, I did only pay $100 for the next MRI and I learned another valuable lesson here as well. When you get an MRI to freestanding practice the radiologist reading the MRI was not a doctor that I had pre-selected. In fact the radiologist reading my MRI was someone I never heard of and knew nothing about and while I wanted to submit the MRI for a second opinion through the doctor's office that I knew and trusted and where my care was all being coordinated, because the MRI came back normal my doctor's office refused to give a second opinion, which is per their protocol.

So through my whole experience what I really learned that could apply for anyone and what I feel like is important to share with everyone tonight is never assume that test treatment and procedures associated with your cancer care you know any care that you're watching simply needs to be in network to be covered. There really might be other requirements that you might not realize. It's also really important to understand your insurance plans so you make the right decisions and you could pick up mistakes and when you get the bill and this happens all the time. Another thing I learned was never pay a bill before matching it to your EOB and calling your insurance company or the doctor's office with any questions about your bill. If the EOB doesn't seem to make sense to you, don't pay it. I

was really happy to hear that Monica had also brought up and mentioned. Also call the facility where you're having your procedure and ask them for the procedure code service code any tax ID information or general information about the facility then call your insurance company and find out what the cost will be beforehand. You can always ask your insurance company to send you a list of in-network providers something. It's helpful to share it. Sometimes it's helpful to share that list with your doctor so that you can maybe point you in the right direction. It's crazy that I'm even saying this because as I was sitting down to write this this actually just happened to me; where I had to schedule another MRI and I called up the place and I gave them my insurance and they said yeah, we're covered but then when I was talking to my insurance, they're like no we don't cover it and there was a little bit of back and forth trying to figure out why and then I realized that the facility where I was going that took my general insurance plan didn't take my specific care plan. So it didn't matter that I had the insurance that they took. So then I had out go back to the insurance company asked them for the list and sort of even learn from my mistakes, which sometimes I keep making. Another thing, I really learned was sometimes there's a trade-off. Well, it may be less expensive; you might not get the care you want. You need to determine what makes the most sense for you and this is something that I'm constantly struggling with is figuring out. How do I weigh my doctors and the people I feel comfortable with reading my results and taking charge of my plan versus the cost of following up with my treatments. So, I hope that hearing this might have been helpful and thank you so much Monica if anyone has questions, I'll be happy to try to answer.

Bonnie Beckoff: Thank you, Sarah. We will now begin our question-and-answer period you can type your question in the text box located in the dashboard to the right of your screen right of your screen. We already have a few questions that came in so we will begin with those.

IV. Question & Answer

Bonnie Beckoff: The first question that we received- Is financial help available to pay for lymphedema compression bandage, bandaged systems, garments and devices?

Right now our best face forward 2.0 program offer subsidies for wigs, scalp cooling and micropigmentation tattooing. Monica- are there ways women can get help with these costs through insurance?

Monica Bryant: So it's going to depend totally on the coverage that you might have because it's going to differ unfortunately. But that's definitely a question that people should be calling and asking their plan about. And also there are a lot of Health Care Providers that know the local boutiques that are able to help bill for these types of services. So unfortunately, it's one of those depends answers based on your coverage.

Bonnie Beckoff: Thank you. Another question that came in Monica that I think this may be something that you can help us with- can you please clarify is the copay a percent of the list price or the amount?

Monica Bryant: The insurer actually pays the provider. So it depends if you are going to an in-network provider, which means that that provider has contracted with the insurance company to accept what's called the allowed amount or the contracted amount. Then the copay is going to be a percentage of that amount. If you're going to an out-of-network provider and they do provide some out-of-network services, then it's going to just be a percentage of what that provider is billing.

Bonnie Beckoff: Perfect. Thank you. Is there a difference between an individual out-of-pocket expense and a family out-of-pocket expense?

Monica Bryant: Yes, and no. So conceptually they are exactly the same thing. But with the family out of pocket maximum, it's usually only going to benefit people that have more than two members of the family because generally what happens is those two people together their individual out-of-pocket maximums are going to make the family out-of-pocket maximum. So then family members three four, etc. are going to benefit from hitting the family out-of-pocket maximum.

Bonnie Beckoff: Okay. Another question we got was how long should you keep an EOB for?

Monica Bryant: So generally speaking. It’s going to be somewhere between three to seven years. And the reason that you want to keep EOBs, is for tax purposes because depending on how much you paid for your medical care, you may be able to deduct those on your income taxes. So generally what we suggest is that you talk with a tax preparer or an accountant about that and then ask them in you know your area what's the best sort of time frame but the kind of rule of thumb is somewhere between three to seven years. I'm one of those people that errors on the seven years.

Bonnie Beckoff: One more question that we have here is what happens if a plan is grandfathered in and is not required to participate in a clinical trial?

Monica Bryant: Fantastic question. So for the rest of you who don't know a grandfathered plan, is a plan that was in existence prior to March 23rd 2010, which is when the Affordable Care Act was signed into law and if it existed prior to that date and hasn't made substantial changes, it's considered grandfathered and those grandfathered plans are exempt from some of the Protections in the Affordable Care Act. And one of those protections is being required to cover the routine costs associated with clinical trials. And so that's just it- they're not required to comply with that for all intents and purposes. The only grandfather plans were still seeing in effect are large group employer-sponsored plans. So if you have a grandfathered plan and you think you want to participate in a clinical trial one way to deal with this is declining your employer coverage and purchasing a standalone plan in your State's health insurance marketplace. That's not always going to be financially feasible for everybody. But it is a possibility.

Thanks to the Affordable Care Act, we're no longer in a situation where we have to take our employers plans with a pre-existing condition. We have some more options now.

Bonnie Beckoff: Thank you. That is so interesting. Thank you so much. The questions keep on pouring in so I'm going to give you a couple of more if that's okay.

Monica Bryant: Absolutely.

Bonnie Beckoff: What is the deal with Medicare not being able to offer incentives like financial aid?

Monica Bryant: So that is an interesting political conversation, but essentially it's about not that Medicare isn't able to provide financial aid, because Medicare does have some financial assistance programs to help individuals with lower incomes pay for the out-of-pocket costs. What I think the question asker might be getting at is- why can't the pharmaceutical companies provide financial assistance to Medicare beneficiaries- and it has to do with looking like they're incentivizing Medicare providers prescribing their drugs. So that has just been a rule that has been in existence. And so for those individuals, we generally try to make sure they're able to get coverage and other ways so that might be you know if they have a Medicare Advantage plan during open enrollment. Maybe now's the time to get to original Medicare or vice versa or changing your part D plan. And like I said when you're making those plan choices the same analysis that I went through with the marketplace plans works when you're trying to figure out well- what are my part deep costs going to be or what are my Medicare Advantage plan costs going to be that same analysis still works. And for anyone who's totally confused about what I just said about Medicare, which is fair Medicare is super confusing. If you are on Medicare or about to be on Medicare, we have an hour-long wedding webinar that goes through all of the different parts and how to make some choices and assessments of what might be the best for you archived on the website.

Bonnie Beckoff: Perfect perfect. Here's another interesting question. What advice do you have for choosing a Medicare plan for people with metastatic cancer?

Monica Bryant: So the lawyer in me is going to start with we don't provide advice. We just provide education so that you can be empowered to make your own choices. But I would say honestly it's the same for everybody. You need to be looking at. What is the plan going to cost you? What are your needs? So original Medicare which is Medicare part A and Part B is fee-for-service Medicare which means that you can go to any provider in the country that accepts Medicare. Whereas if you pick a Medicare Advantage plan, otherwise known as part c those are going to have a smaller networks of providers. So I live in Chicago and there is what we refer to as snowbirds. So, you know some of who gets part of their care in Chicago during the summer and maybe gets part of their care in Florida in the winter. An advantage plan with that small Network would be a terrible idea for those people probably original Medicare would be a better

choice. Um..so I think it's really it depends on everybody's own situations. And again, if you're making those choices, I would I would really recommend watching that webinar because it kind of gives you start to finish the building blocks on how to make those decisions.

Bonnie Beckoff: Great information. Another question that came in what do I do if I don't have insurance, but I feel a lump.

Monica Bryant: That's a tricky one. Well it again is going to depend on your situation. So in all states, there's a breast and cervical screening program. So that's definitely an option for you to go get screened and in some states not all states, there's also a treatment program associated with that. There is some income requirements associated with that would be certainly one option now, even if you don't have insurance now, I wouldn't suggest delaying getting it checked out you may have to pay for those initial appointments out of pocket, but remember open enrollment is coming up and so that's the time where you can purchase the new plan and thanks to the Affordable Care Act, you cannot be denied based on a pre-existing condition. So it's not a perfect situation. We don't you know, we don't want people to be uninsured and be in that situation, but we certainly know that it happens. And again, my good news is thanks to the Affordable Care Act. We have some more options now than we did even five years ago.

Bonnie Beckoff: Thank you. Can you speak more about the services that you mentioned where you pay them to help with claims and appeals?

Monica Bryant: Sure. So there are Professional bill reviewing services out there. They all operate a little bit differently. Some will look through all of your claims and everything that you've paid and look to see if there's any mistakes or maybe you shouldn't have paid as much or a claim was denied. Some of them charge a flat fee up front, some of them charge a flat fee plus a percentage of any money they get back for you. Some of them just charge a percentage of the money they get back for you. Now, I generally don't recommend these for people who maybe think there was only you know, one mistake because when you start doing the cost-benefit analysis, it may not work out but for folks that have been through extensive treatments many providers and think that there are mistakes it might be a worthy endeavor.

Bonnie Beckoff: Excellent. Excellent. I have one final question. How do I find out if my employer provided Insurance requires me to have Medicare Part B.

Monica Bryant: So I'm assuming this is for an individual who is over the age of 65, but is still working. Many employers many individuals in those situations will keep part A because assuming they've worked and paid into the system part A is going to be free and decline Part B and just keep their employer-sponsored insurance, but occasionally when somebody has what's referred to as retiree insurance from their employer those plans will require individuals to have Medicare in addition to the retiree only plan and basically what ends up happening is and I'm generalizing here but Medicare usually pays first and then the employer play plan acts is what's

called a supplemental plan and picks up those out-of-pocket costs. If you're unsure of what your employer is requiring, I absolutely suggest that you talk to who over at your job handles employee benefits that could be HR. It could just be a person depending on your employment setting to see what their rules are. You could also call the number on the back of your insurance card, but I always I generally recommend that people do both of those things and make sure that the answers match because the reality is sometimes when you call people don't always know exactly what you're getting at or have all of the information. So it's always good to do your due diligence to make sure that you're as protected as you can be.

V. Conclusion

Bonnie Beckoff: Wow, thank you so much Monica such valuable information. I really appreciate it. I think that's going to end our question and answer session for now. Your feedback is greatly important to us and we are committed to staying relevant by enhancing our programs to reflect the growing and changing needs of the women and families of our shared community with that in mind. You will be receiving an evaluation in your email box and the next couple of these please take a few minutes to complete the survey. I want to thank Monica and Sarah, we truly appreciate the information that you shared with us and that you shed light on such important information and the importance of perseverance a video and transcript for tonight's presentation will be available on chart share its website. You can access it by going to www.sharsheret.org. It's on your screen right now.

I would once again like to think Daiichi Sankyo, Amgen, MacroGenics, and The Siegmund and Edith Blumenthal Memorial Fund and our partners at triage cancer for sponsoring tonight's program, and their continued support of Sharsheret. The conversation doesn't have to stop here. You can visit us at www.sharsheret.org or call us at 866-474-2774 to discuss tonight's topic or any other concerns you are facing. Additionally, please don't hesitate to call us about our new financial subsidy program best face forward 2.0 to schedule an appointment to begin the application process for wigs coal caps and 3D tattooing of the nipple and areola or to help with any insurance questions that you may have with. Thank you so much for joining us and have a great rest of your evening.

VI. Speakers' Biographies

Monica Fawzy Bryant, Esq, is a cancer rights attorney, speaker, and author, dedicated to improving access to, and availability of, quality information on healthcare-related issues. Monica is the Chief Operating Officer for Triage Cancer, a national, non-profit organization that provides education and resources on cancer survivorship issues.

Previously, Monica was Midwest Regional Director for a national cancer rights organization she forged relationships with cancer organizations, hospitals, law firms, other community partners, and members of underserved communities. Prior to relocating to Chicago, Ms. Bryant served as Legislative Counsel for U.S. Congresswoman Linda T. Sanchez and Law Clerk for U.S. Senator

Dianne Feinstein. During her time in Congress, Ms. Bryant focused on health, justice, civil rights, and women's issues. She was also heavily involved in the nomination hearings for United States Supreme Court Chief Justice John Roberts and Justice Samuel Alito.

Throughout her career, Monica has provided hundreds of educational seminars, written articles and blogs, and appeared on community television and radio shows discussing healthcare-related legal issues.

Additionally, Monica is an Adjunct Law Professor at John Marshall School of Law in Chicago, teaching a class on Cancer Rights. Monica currently serves on the Executive Committee of the American Bar Association's Breast Cancer Task Force.

Monica received a Bachelor's of Arts degree in Law & Society, with an emphasis in criminal justice, and Psychology from the University of California Santa Barbara and a Juris Doctor from The George Washington University Law School. She is a member of both the California and Illinois State Bars.

VII. About Sharsheret

Sharsheret, Hebrew for "chain", is a national non-profit organization, improves the lives of Jewish women and families living with or at increased genetic risk for breast or ovarian cancer through personalized support and saves lives through educational outreach.

With four offices (California, Florida, Illinois, and New Jersey), Sharsheret serves 150,000 women, families, health care professionals, community leaders, and students, in all 50 states. Sharsheret creates a safe community for women facing breast cancer and ovarian cancer and their families at every stage of life and at every stage of cancer - from before diagnosis, during treatment and into the survivorship years. While our expertise is focused on young women and Jewish families, more than 15% of those we serve are not Jewish. All Sharsheret programs serve all women and men.

As a premier organization for psychosocial support, Sharsheret's Executive Director chairs the Federal Advisory Committee on Breast Cancer in Young Women, Sharsheret works closely with the Centers for Disease Control and Prevention (CDC), and participates in psychosocial research studies and evaluations with major cancer centers, including Georgetown University Lombardi Comprehensive Cancer Center. Sharsheret is accredited by the Better Business Bureau and has earned a 4-star rating from Charity Navigator for four consecutive years.

Sharsheret offers the following national programs:

The Link Program

- Peer Support Network, connecting women newly diagnosed or at high risk of developing breast cancer one-on-one with others who share similar diagnoses and experiences
- Embrace™, supporting women living with advanced breast cancer
- Genetics for Life®, addressing hereditary breast and ovarian cancer

- Thriving Again®, providing individualized support, education, and survivorship plans for young breast cancer survivors
- Busy Box®, for young parents facing breast cancer
- Best Face Forward®, addressing the cosmetic side effects of treatment
- Family Focus®, providing resources and support for caregivers and family members
- Ovarian Cancer Program, tailored resources and support for young Jewish women and families facing ovarian cancer
- Sharsheret Supports™, developing local support groups and programs

Education and Outreach Programs

- Health Care Symposia, on issues unique to younger women facing breast cancer
- Sharsheret on Campus, outreach and education to students on campus
- Sharsheret Educational Resource Booklet Series, culturally-relevant publications for Jewish women and their families and healthcare Professionals

VIII. Disclaimer

The information contained in this document is presented in summary form only and is intended to provide broad understanding and knowledge of the topics. The information should not be considered complete and should not be used in place of a visit, call, consultation, or advice of your physician or other health care Professional. The document does not recommend the self-management of health problems. Should you have any health care related questions, please call or see your physician or other health care provider promptly. You should never disregard medical advice or delay in seeking it because of something you have read here.

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