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■ HEALTHCARE:
IF YOU'RE PREGNANT

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■ HEALTHCARE:
IF YOU'RE ON BIRTH CONTROL

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■ HEALTHCARE:
IF YOU HAVE A MENTAL HEALTH ISSUE

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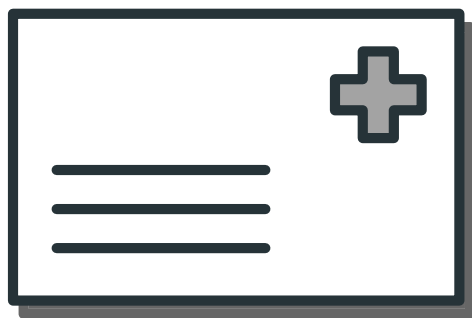
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■ HEALTHCARE:
GLOSSARY

- BUT FIRST: DO YOU HAVE INSURANCE?
- I HAVE INSURANCE. WHAT PRENATAL SERVICES WILL BE COVERED IN FULL?
- WHAT STEPS SHOULD I TAKE BEFORE I GIVE BIRTH?
- WHAT BENEFITS ARE COVERED AFTER DELIVERY?
- WHAT ELSE DO I NEED TO DO ONCE THE BABY ARRIVES?

HEALTHCARE IF YOU'RE PREGNANT

■ But first: Do you have insurance?



The first hurdle, obviously, is making sure you have adequate health insurance. “The maternity care protections we all worked for in the ACA are being undermined these days. There are more and more plans being sold that don’t comply with the law,” says Cheryl Fish-Parcham, director of access initiatives for Families USA. These include short-term, indemnity, and association health plans. It’s likely if you have one of these, maternity care won’t be covered. “Be wary about buying one of these,” she says.

IF YOU’RE UNINSURED: In 2010, two-thirds of unintended births, and half of births overall, were paid for by public insurance programs like Medicaid, according to the Guttmacher Institute’s most recent analysis. If you don’t have insurance and have a lower income (based on the federal poverty level), check if you qualify for Medicaid, which is insurance paid for by states and the federal government.

“Medicaid income guidelines may be fairly generous depending on your state,” Fish-Parcham says. For instance, some states count the unborn child as a household member, which can increase what your need looks like and qualify you for the program, she says.

A final word on insurance—yes, you need it. If you don’t have it through an employer, a marketplace plan you purchased, or Medicaid and you get pregnant, you’re still on the hook for your medical bills. You’ll have to pay out of pocket for your appointments and will receive a hefty bill from the hospital after delivery.

According to one study from the University of California in San Francisco, women could be charged between \$3,000 and \$37,000 for a vaginal delivery, and \$8,000 to \$71,000 for a C-section in California. That is not a bill you want, and one that can only go up exponentially if you or your baby has complications and requires an ICU or NICU stay.

■ I have insurance. What prenatal services will be covered in full?



SUPPLEMENTS

Prenatal vitamins and folic acid supplements and are covered. You may need a prescription from your doctor or you can pay for them using your tax-free flexible spending account (FSA), health savings account, (HSA), or health reimbursement account (HRA). These vitamins have been shown to prevent birth defects, primarily neural tube defects, which compromise the growth of the brain, spine, or spinal cord (spina bifida is one example of this kind of defect). If you're looking to become pregnant, it's important to take either 400 to 600 mcg of folic acid alone or a prenatal multivitamin that contains folic acid.

HEALTH SCREENINGS

Covered tests include those for anemia, gestational diabetes, Rh incompatibility, gonorrhea, syphilis, hepatitis B, UTIs, and preeclampsia (for women with high blood pressure). These screenings either happen on a routine basis during prenatal visits or are a one-time occurrence depending on how far along you are in your pregnancy.

TOBACCO INTERVENTION AND COUNSELING

Twenty percent of pregnant moms on Medicaid smoke, which can lead to preterm births and sudden infant deaths. Plans offer options for helping women quit.

BUT: IT'S NOT A PERFECT SYSTEM

A 2015 report by the National Women's Law Center (NWLC) found numerous violations of the mandatory ACA maternity coverage, like limiting the number of ultrasounds or prenatal visits—which your plan may not cover in full, though Medicaid programs in most states do cover ultrasounds—or imposing restrictions on a woman receiving emergency maternity care outside of her area.

If you're pregnant, the best way to protect yourself from surprise bills is to do your homework. So, take a deep breath and read on.

■ What steps should I take before I give birth?

CALL YOUR INSURER TO TALK COSTS

When you know you're pregnant, call your insurance company. They can give you an estimate of what additional services are covered beyond the ACA requirements (like chromosomal screenings, ultrasounds, the copay for office visits, etc), as well as provide an estimate of how much the birth will cost, which can vary widely. For instance, when I had my first son in 2013, we paid about \$2,000 in hospital bills. This year when I had my second son, we had the same insurance company but a different plan and we paid nothing.

SPECIFICALLY, HERE ARE THE QUESTIONS YOU SHOULD ASK YOUR INSURANCE COMPANY:

- What's the estimated cost of a vaginal birth? C-section?
- What services are covered under my plan?
- How do these services fulfill my deductible? (That's the amount you need to pay out of pocket before your insurance starts footing the bill.)
- Is my preferred doctor and hospital in-network? Again, those fully covered services listed above are only free when performed by a doctor in the insurance company's networks.
- Are delivery services like anesthesiology or visits from additional staff going to automatically be billed in-network (even if they're technically out-of-network)?
- When the baby is born, will the baby itself be charged separate fees? That can easily double your burden for hospital services.
- Do I need to call the insurer for pre-approval/prior authorization before I go to the hospital to give birth? Yes, sadly, this is sometimes a thing.
- How late in my pregnancy can I order my free breast pump?
- Is the 6-week postpartum checkup covered?
- If you're interested in a home birth, ask if it's covered. But you may be out of luck. For example, Aetna says they consider planned

deliveries at home "not medically appropriate," deferring to the American College of Obstetricians and Gynecologists' recommendations. In some states, however, Medicaid will cover a home birth.

- If you're interested in hiring a doula or a midwife, ask if they're covered. Medicaid reimbursement for doulas differs by state but has been difficult to implement, notes a 2016 report from the NPWF. Minnesota is one such state that offers this benefit through the Minnesota Health Care Programs. Midwife services, on the other hand, are more likely to be covered under insurance, and are allowed through Medicaid.

DO SOME READING

Also, it's worth noting that the insurance rep you talk to may not have all the information, depending on how well they're informed, and it's smart to double check their word against your plan. ("So-and-so agent told me that ultrasounds were covered" will not fly when disputing a charge.)

Health plans are required to have a Summary of Benefits and Coverage. Page 7 of most summaries will explain coverage for childbirth and how much you will likely owe for the birth, and your plan may also have a separate document spelling out maternity coverage. They may even provide an online cost estimate calculator that can give you a picture of what you might owe.

PREPARE FOR MONEY QUESTIONS

From there, many doctor's offices encourage you to appropriately save for the cost of prenatal bills and delivery. My doctor for my first child had us pay a deposit at 28 weeks to defray costs not covered by insurance. My doctor for my second baby, at a different practice, simply sent home a flyer encouraging us to call the insurance company to plan for the possible financial burden. Another option is maxing out a health savings account, or HSA, (if you have a high-deductible plan) or socking money away in a flexible spending account, or FSA, to help cover some costs.

■ What benefits are covered after delivery?



Here's what should be covered without a copay or coinsurance:

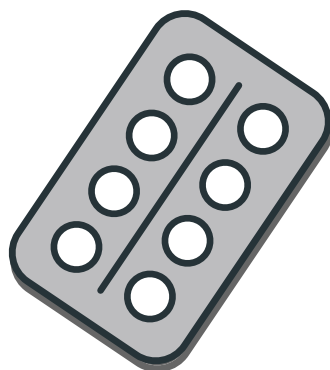
NEWBORN SCREENINGS

Before you're allowed to leave the hospital, your newborn will receive a bilirubin test (to check for jaundice), a blood screening, hearing screening, and more. These tests are all covered by plans thanks to the ACA. It's important to know this, should you incorrectly receive a charge for them. (Had I known that these were covered, I could have fought back against the hearing test that was denied by my insurance, which I ended up paying for out-of-pocket.) Note that the 6-week postpartum check-up isn't required to be covered under the ACA, but most Medicaid programs cover postpartum visits.

BREASTFEEDING NEEDS

Breastfeeding support and counseling (such as a lactation consultant), as well as breastfeeding equipment and supplies are all covered. The biggest perk from ACA-compliant plans is a free breast pump, which can normally run in the hundreds of dollars. Each plan has its own rules about exactly when you can order one, so if you want to breastfeed, ask your insurance about your benefits. Alternatively, the company Aeroflow Breastpumps will also contact your insurance for you to verify coverage, give you qualifying options, and allow you to order one. (In my experience, Aeroflow has saved a lot of time and confusion.)

■ What else do I need to do once the baby arrives?



GET YOUR BABY ON YOUR HEALTH INSURANCE

In most cases, you have a 30-day window to add your baby to your insurance. (If you have an HMO-type plan, you'll also have to formally declare a doctor for the little one.) You can do this by calling them or going online. However, some insurers will ask for a social security number for the baby, something they won't receive until they're five or six weeks old. Helpful! Ask your insurer what you should do to get around this.

If you bought a plan on the Marketplace, you don't have to wait until the next "open enrollment" to add your baby: Pregnancy qualifies you for a special enrollment period when you can enroll your baby in your plan or change your coverage.

CONTRACEPTION

After you give birth, you'll likely want to talk to your doctor about birth control. With the exception of employers who have a religious exemption, the ACA requires that insurance plans cover all FDA-approved methods of contraception and sterilization for women without a copay.

REVIEW YOUR BILL

Anyone who's looked at a hospital bill—especially for a delivery—knows how batshit crazy they can be. If you're in doubt about a bill, one option is to check with your state's insurance department, which regulates insurance companies, Fish-Par-cham advises. If you were denied coverage you feel you were entitled to, you're also able to appeal to your insurance company, says Glover, though she acknowledges that competing demands on time and resources with a newborn can make this, uh, challenging. It's easier said than done, but doing what you can up front to make sure you're covered and know what your plan entails can save you a lot of grief in the end.

WHAT ELSE CAN I DO IF I THINK I'M BEING INCORRECTLY CHARGED?

The National Women's Law Center also notes that many insurers fail women by not complying with the ACA coverage requirements. If yours is giving you trouble, you can contact their hotline, CoverHer, for help.

- I HAVE INSURANCE. WHAT FAMILY PLANNING SERVICES ARE COVERED?
- WHICH BIRTH CONTROL METHODS DOES INSURANCE COVER?
- WHAT RELIGIOUS EXEMPTIONS DO I NEED TO KNOW ABOUT?
- I DON'T TRUST MY INSURANCE COMPANY. CAN I JUST ASK MY DOCTOR IF IT'S COVERED?
- I THINK I WANT AN IUD OR IMPLANT. ANYTHING ELSE I SHOULD KNOW ABOUT GETTING ONE OF THOSE?
- UGH, MY INSURANCE SENT ME A BILL. WHAT NOW?
- WHAT IF I WANT MY TUBES TIED?
- ALL THIS IS NICE, BUT I DON'T HAVE HEALTH INSURANCE. HOW CAN I GET LOW-COST BIRTH CONTROL?

HEALTHCARE IF YOU'RE ON BIRTH CONTROL

IF YOU'RE ON BIRTH CONTROL

BY JESSICA MIGALA

You don't want babies right now. Or any more babies than you currently have. Or any babies ever. Whatever your exact situation, getting the right birth control is critical.

"We know when women are using the method that's not the best match for them, they're less likely to use it correctly or consistently," says Mara Gandal-Powers, director of birth control access and senior counsel for the National Women's Law Center. Incorrect or inconsistent use can lead to an unintended pregnancy, and nearly half of all pregnancies in the US are unintended. The average American woman who has two kids will still spend about three decades trying to avoid unintended pregnancy, says the Guttmacher Institute.

The Affordable Care Act (ACA) has been a game-changer when it comes to women's ability to control if and when they get pregnant. The law required most plans to cover birth control with no out-of-pocket costs and also led to millions more people getting health coverage. In 2013, 12.5 million reproductive-age women didn't have insurance; and thanks to Medicaid expansion and gains in private insurance, that number fell to 7.4 million in 2016, according to data from the Guttmacher Institute.

But the ACA isn't perfect and there are still people who don't have insurance. Here's what you need to know.

■ I have insurance. What family planning services are covered?

Again, birth control is covered at no cost, but we'll get to that in a minute. Whether you're covered under Medicaid, a plan you bought on the ACA Marketplace, or insurance you get through an employer or school, here is what's covered with no out-of-pocket costs (that is, without a copay, coinsurance, or deductible). If you wrongly get charged for any of these things, you can push back on your insurance company—more on how to do that below.

AN ANNUAL WELL-WOMAN EXAM

Even if you don't need a Pap smear or HPV test this year, you should still go in for this exam. This is essentially a physical, though it needs to be billed as a "well-woman visit" to be fully covered. There, you'll chat about your medical and family health history, sexual health concerns, lifestyle habits, mental health, and relationship safety. You'll also receive a pelvic exam (if you're over 21), and you may get a breast exam as well. Any immunizations and other screenings will also be given depending on your health needs. Cervical cancer screening through a Pap smear is recommended for women every 3 years starting at age 21. The HPV test can be done along with a Pap every five years starting at age 30.

STD SCREENINGS

As part of preventive care benefits for women, all Marketplace plans are required to cover certain STD screenings for people at a higher risk without a copay or coinsurance when you see an in-network doctor. (This applies to many insurance plans as well. Ask yours what they cover.) The covered tests include HIV tests for all sexually active women, chlamydia and gonorrhea screenings for all sexually active women younger than 25, or women over 25 who have new or multiple sex partners, or a sex partner who has an STD, or people who use condoms inconsistently in relationships that aren't mutually monogamous.

Insurance plans also have to cover syphilis tests for women with HIV and women who are pregnant. If you're not in any of these groups and you want an STD test, ask your doctor if your insurance will cover it.

HPV VACCINE

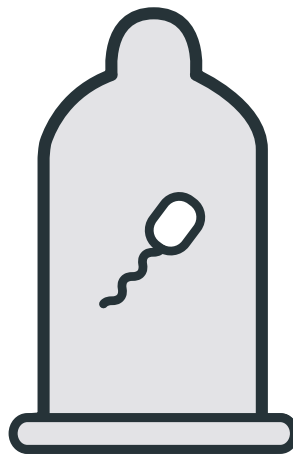
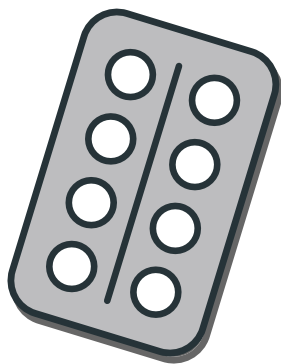
One in four people have HPV (human papillomavirus), a virus that can cause cancer in both men and women. The ACA requires most private insurance plans to cover vaccination at no cost for people ages 9 through 26 (both men and women), though following FDA approval for people ages 27 to 45, insurance plans might start covering the vaccine for this group as well. Preteens and teens ages 9 through 14 need two doses, while those ages 15 to 26 need three doses. If you received Medicaid through the ACA expansion, the HPV vaccine is covered; otherwise, Medicaid coverage of the vaccine is state-dependent, though most states offer coverage for women, according to the Kaiser Family Foundation.

BIRTH CONTROL

This is one of the reasons why the ACA is so critical for women's health when it comes to their reproductive decisions. "There are 62.4 million women who are eligible for birth control without out-of-pocket costs thanks to the ACA. That's huge," Gandal-Powers says. "For the vast majority of people who have birth control coverage due to the ACA, they're experiencing good coverage." But that's not always true across the board, and "when it doesn't work, it's extremely frustrating," she says.

There are some common loopholes and roadblocks you may need to clear to get free birth control. We've all heard stories of friends whose insurance wouldn't cover such-and-such brand name or who were charged for an IUD when they shouldn't have been. Keep reading to fully equip yourself with what you need to know.

■ Which birth control methods does insurance cover?



The ACA requires that 18 methods of contraception for women (the 20 types listed on FDA.gov minus vasectomies and male condoms) are covered for free, without co-pay or co-insurance, when prescribed by a doctor in your insurance network. This includes pills, patches, rings, diaphragms, sponges, the implant, intrauterine devices (IUDs) with and without hormones, emergency contraception (e.g. Plan B), and female sterilization. (Note: The sterilization implant is on the FDA's list but the only one sold in the US, Essure, will be taken off the market by 2019 following lawsuits.)

This birth control benefit applies to most private health insurance plans, as well as plans people buy themselves. We say “most” plans because a small number of employer plans remain grandfathered under the ACA, so they don't have to comply with this benefit, and if your employer is religiously affiliated, there are other exemptions (more on that below).

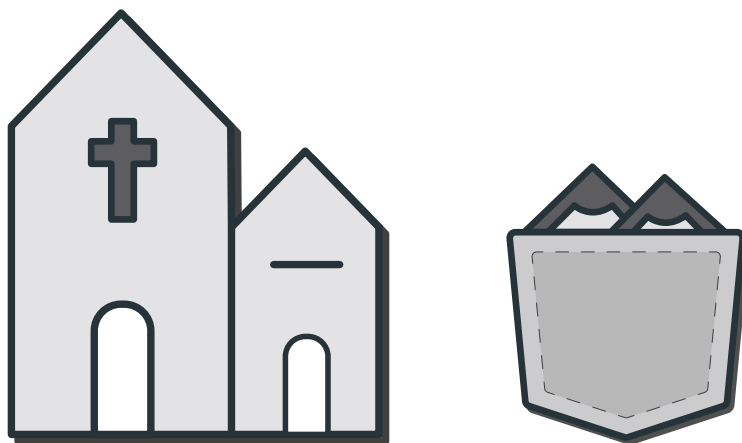
The office visit to get the prescription and counseling on the right method for you are also fully covered—and it's important that you take advantage of this benefit, since, as mentioned above, women who have the birth control that best suits them are more likely to use it and use

it correctly, Gandal-Powers says. The ACA's contraceptive coverage provision allows you to pick which method works best for you without having to worry how much it will cost. So, for instance, if you know you're not consistent at taking the pill, maybe you'll opt for a long-acting device that might have been too expensive for you before the ACA required it to be covered. (Power to Decide also offers a Bedsider tool that explains your range of contraceptive choices and helps you compare multiple methods.)

However, as the Guttmacher Institute points out, there are certain loopholes that can saddle you with an unexpected bill, writing that “under the guarantee, health plans may apply formularies, prior authorization requirements, and similar restrictions within a method category.” This may be to influence patient choice, which isn't very helpful since drugs within the same category—like birth control pills, for example—can cause different side effects or may not be right for every woman.

Some states may have even more generous coverage than what the ACA offers, like covering a full year's supply of contraception at once or even vasectomies. Check out Guttmacher's site to see what your state specifically covers.

■ What religious exemptions do I need to know about?



If your employer is a religious institution like a church, they don't have to cover contraception and you may have to pay out of pocket. If you work for a non-profit religious hospital, university, or other organization, they also don't have to pay for contraception—but the insurance company does so you can still get it at no cost anyway. The insurance company is supposed to step in and arrange birth control coverage on your plan, Gandal-Powers says. (If not, check out the section below on what to do if you get charged.)

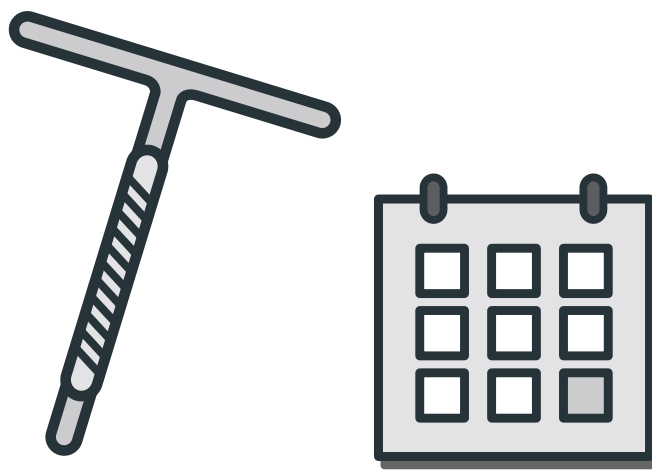
Now, let's talk about something that happened in October 2017. A mandate from the Trump administration expanded employer's rights to deny insurance coverage for birth control for any ethical, religious, or moral objection, and it extends to for-profit companies. "This would have basically driven a Mack truck through the contraceptive accommodations," says Gandal-Powers. However, she notes that these rules are currently stalled by two nationwide injunctions in the circuit courts. Right now, they are not in effect—a very good thing for your health.

■ I don't trust my insurance company. Can I just ask my doctor if it's covered?

Yup. It's easy to assume that they're there for your physical care, but they can also help with insurance concerns. So, don't be afraid to ask them if the prescription is covered under your plan. "If I don't know the answer, I know someone in my

office does. At every office there is usually a point person to talk to about insurance issues and logistics," says Kristyn Brandi, an OB/GYN in New Jersey and board member with Physicians for Reproductive Health.

■ I think I want an IUD or implant. Anything else I should know about getting one of those?



Yes, glad you asked. Some clinics and doctor's offices carry these super-effective, long-acting methods—which last between three and ten years—and some don't, Brandi says. If yours doesn't, the office will have to order it and you'll need to come back to get it inserted. If you think you may be interested in an IUD or implant, ask the doctor's office while making your appointment if they stock those.

For these more expensive devices or sterilization procedures, it's always a good idea to call your insurer to ask if the specific one you're getting is covered. Ask the administrative team in the office for the insurance codes (for the counseling, the device itself, and the insertion procedure) and call your insurance company to double check your coverage. You have a right to your Summary of Benefits, which outlines these details. This small amount of work on your part can save you from a surprise bill.

While we're talking about these devices, you should ask yourself if you want to get pregnant within the next year or so—and share this info with your OB/GYN so they can help counsel you on what method is best. If you do want to get pregnant in the near future, then a hormonal or barrier method (like the pill or diaphragm) may be best for you. An IUD or implant can still work in this case, but be prepared that there's legwork to get the device put in and taken out, and you have to decide if that's worth it for you, Brandi says. (She, however, does not recommend the birth control shot, brand name Depo-Provera, if you're planning on getting pregnant soon. "Studies show that it can take up to a year to return to fertility after the shot," she says.)

■ Ugh, my insurance sent me a bill. What now?

You thought that the Rx your doctor gave you would naturally be covered. But now you went to the pharmacy and they asked you to pay up. Or you got an IUD and then were sent a bill for it in full. Don't stand for it. "If you're new to insurance coverage, it can be daunting to take on your insurance company, or you might not know you can. But it's worth it," says Gandal-Powers.

Because of the ACA, you should be able to get the method of birth control the doctor prescribed. If it's a brand name, insurance plans have a process in place to get you this prescription (versus them trying to stick you on a generic). While it should be covered, "we know this doesn't always work perfectly with insurance companies,"

Gandal-Powers says. In that event, the National Women's Law Center has their free CoverHer hotline (phone or email). The CoverHer site also outlines what your rights are and includes templates of appeal letters to send to your insurance.

The good news is that since the NWLC published a report in 2015 detailing problems with insurance companies not complying with the ACA (like only covering the pill or the ring, not both, since both are hormonal options), additional guidelines circulated at the end of the Obama administration that made insurance companies more accommodating, Gandal-Powers explains.

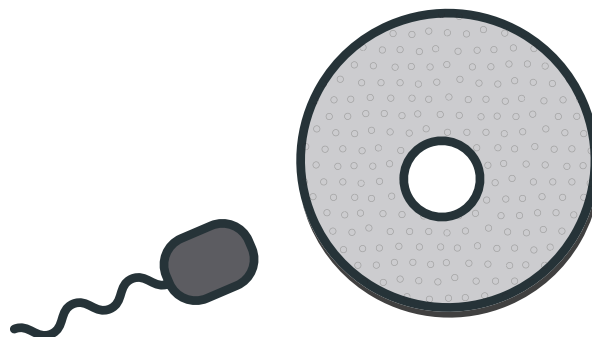
■ What if I want my tubes tied?

The official name for this is a tubal ligation, a surgical female sterilization procedure where the two fallopian tubes are blocked or cut so sperm can't reach an egg. The surgery is fully covered by insurance thanks to the ACA. While it can be reversed in some instances with another surgery, a tubal ligation is usually permanent. For that reason, some women report that their doctors sometimes won't do the procedure, warning them that they may change their mind.

"It personally makes me very angry when I hear those stories," Brandi says. "If a woman decided she doesn't want children or more children, that's it. End of conversation—regardless of her age or partner status." Of course, your doctor may give their medical opinion on your specific case. If your doctor is pushing back based on their views on your

family wants (rather than if, say, it wouldn't be medically safe for you), seek a second opinion.

If you're unsure if it's right for you, you can reach out to the office of a doctor who does tubal ligations of people your age and ask if you can talk to a similar patient, Brandi suggests. It can be a little tough to coordinate, but sometimes they will refer to another patient so you can understand the procedure in a new way.



■ All this is nice, but I don't have health insurance. How can I get low-cost birth control?

If you don't have insurance, the difficult reality is that you have to be your own advocate, says Jennifer Johnsen, senior director of digital programs and education at Power to Decide, a non-profit that works to prevent unplanned pregnancy. This can be tough depending on your job, access to transportation, and availability of health clinics that provide contraceptive services at low or no cost.

Power to Decide's Bedsider database can help you find a health center near you to get birth control, and they also have a tool to help you determine if you qualify for free contraception. According to Planned Parenthood, you may be able to get it for free if you qualify for Medicaid or state programs even if you're not enrolled in them. Both Planned Parenthood health centers and health clinics that get federal family planning funds known as Title X grants will provide low- or no-cost birth control, cancer screenings, and STD tests depending on your income. You can search for Planned Parenthood health centers and Title X health centers online. You can also search "sliding scale birth control" and your city name. (If you just need STD testing, you can search the database at gettested.cdc.gov and select "show only free or low cost providers.")

Before you go, know that it may not be as simple as going in for an appointment and walking out with birth control. Some health centers will dispense prescriptions on site, while others require you to make a separate trip to a pharmacy to fill it. And if it's a long-acting method like the shot, implant, or IUD, you may have to go back to the center to get it administered or implanted.

This large amount of commitment can be a deterrent to going, but knowing what you're in for first can help you make arrangements for transportation and time off. If you have children

but are hesitant to go because you don't have childcare available, some of these centers have accommodations that you can bring your kids.

From there, you can call the clinic and ask about their birth control options and how they can help you get the method you want without health insurance. (They may say they can't, and you'll have to look at another center.) Johnsen also notes that a telemedicine provider, who prescribes birth control through an app or online video consultation, can be a more accessible way for some people to get birth control. Some will require a flat fee of as low as \$15 a month without insurance (and many do take insurance).

The Affordable Care Act has done a lot of good but, yes, there are still many people without insurance. The 7.4 million women of reproductive age without insurance fall into a "coverage gap," Johnsen says.

"[Many of] these women do not have children, they have incomes below 138 percent of the poverty line, and they live in one of the 17 states that have not yet expanded Medicaid," she says. Johnsen adds that 11 of these states have Medicaid Family Planning Waivers, which allow women with low incomes to qualify specifically for family planning coverage, rather than full health insurance. The Kaiser Family Foundation has a list of states that allow women to get Medicaid coverage for birth control.

Additional coverage gaps include legal immigrants (some green-card holders have to wait 5 years before enrolling in Medicaid) and undocumented people. Then, there's geographical concerns. So-called "contraceptive deserts" leave 19 million women without access to health clinics that provide the full range of FDA-approved birth control methods.

0003: HEALTHCARE IF YOU HAVE A MENTAL HEALTH ISSUE

- 00001: HEALTHCARE: IF YOU'RE PREGNANT
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- 00007: HEALTHCARE: IF YOU'RE TRANS
- 00008: HEALTHCARE: GLOSSARY

HEALTHCARE IF YOU HAVE A MENTAL HEALTH ISSUE

- WHERE DO I EVEN START?
- WHAT KIND OF THERAPIST SHOULD I LOOK FOR?
- I HAVE INSURANCE. DOES IT COVER THERAPY?
- DO SCHOOLS OR EMPLOYERS OFFER THERAPY?
- I NEED SOMETHING A LOT CHEAPER. WHAT ELSE CAN I TRY?
- I HAVE REALLY SPECIFIC ISSUES. DO I NEED TO SEE A SPECIALIST?
- WHAT ARE MY OTHER OPTIONS?
- WHAT IF I HATE MY THERAPIST OR CAN'T AFFORD TO GO ANYMORE?
- WHAT KIND OF HEALTH PLAN SHOULD I GET IF I NEED THERAPY?
- WHAT HAPPENS IF I NEED TO TAKE EXTENDED TIME OFF FROM WORK?

IF YOU HAVE A MENTAL HEALTH ISSUE

BY CINDY KUZMA

Chicago therapist Rachel Kazez understands exactly how challenging navigating the mental health system can be. In addition to providing therapy to families, couples, and individuals—with a speciality in young adults—she founded and operates a service called All Along, which specifically helps people sort through the confusion to find the right services for them.

While she knows how overwhelming the hunt for psychological care can feel, she's optimistic that anyone can manage it with some basic prep. "It might take work, but it's possible for everybody to find good mental health treatment that they can afford," she says.

Here are a few of the most important steps to take.

■ Where do I even start?

Recognizing you have challenges you can't handle on your own is really all the information required to start reaching out. Sure, it might be helpful beforehand to put some thought into what kind of therapy or therapist you're looking for, Kazez says, but starting your search can lead you to answers you didn't even know existed.

"You don't have to figure this out all by yourself," she says. Even if the first place you call or visit doesn't treat the types of issues you're dealing with—for instance, if you find out they specialize in veterans or younger children—the staff might still be able to recommend other resources.

And once you find a practice or clinic that can offer you a slot, they'll offer even more guidance: "Often the process of doing an initial assessment or intake or whatever it's called at the place you're going, that process is about clarifying your needs and preferences for treatment and even referring you out somewhere else if that's what you need," she says.

■ What kind of therapist should I look for?

While you don't have to get hung up on it in advance, it may help to understand that when it comes to mental health, there are a wide variety of providers. Psychiatrists are physicians—MDs or DOs who can prescribe medications—while therapists who have PhDs or PsyDs can't write prescriptions (though they might team up with a doc who does to manage your care).

People with master's degrees in psychology, counseling, or social work can also practice on their own after about two years, provided they have the correct licensing in their state. They might be called licensed clinical social workers (LCSW), licensed mental health counselor, licensed clinical professional counselor, licensed marriage and

family therapist, or some combination of those terms—all indicating they've met state standards for education and experience. At some clinics, Kazez says, a case manager might help you connect with a therapist and also provide some supportive counseling.



■ I have insurance. Does it cover therapy?

Most employer-based health insurance plans cover mental health services, and all plans purchased through the Affordable Care Act's marketplace must include it (it's what the government considers an essential health benefit). So if you have coverage that does, that's often a good place to start, says Angela Kimball, national director of advocacy and public policy at NAMI, the National Alliance on Mental Illness. Check your insurance company's website or call the number on the back of your card and ask for a list of mental health service providers in your network.

Websites like the American Psychological Association and Psychology Today offer online directories where you can search for therapists by area, speciality, and types of insurance accepted. Often, there's a brief profile, too, which can help you gauge whether you might click with this person and their approach, Kazez says. For instance, do you want a therapist who'll direct you through a series of steps toward an end goal, or someone who's more likely to listen and reflect back to you as you sort through your issues?

Of course, you'll want to call and double-check that they take your specific plan—they might take some plans offered by your insurance company and not others, or the information the company gave you may be outdated. Be especially cautious if you have Medicaid for insurance, Kazez says. Often, Medicaid plans are organized by what's called a managed care organization. To be covered, the provider you see not only has to accept Medicaid, but also work with your specific managed care organization. Again, the staff at the offices or clinics you contact can help you sort through all this.

One note: Just because something's covered doesn't mean it's free. You'll typically have a flat fee called a copayment for each visit. Depending on your plan, coverage for therapy visits and also for bigger expenses like inpatient stays might not kick in until you meet a yearly minimum called a deductible, meaning you'll have to pay more out-of-pocket at first before the flat fees per visit kick in. Your insurance company can provide specifics.

■ Do schools or employers offer therapy?

If you don't have insurance, your plan doesn't cover mental health services, you can't find a therapist in your network accepting new patients, or you can't afford the copayments or deductibles, you still have options. One way to start is checking out the resources immediately around you. If you're still in

school, visit your campus counseling center; services there are usually available at little or no cost to students. Working? Some employers offer employee assistance programs (EAP) that include confidential counseling—ask your human resources department.

■ I need something a lot cheaper. What else can I try?



Online searching can also yield a wide range of options. Plug in “community mental health clinic” or “low-cost counseling” and the name of your town or a nearby city. “You might be surprised by what pops up,” says Paul Fugelsang, a licensed professional counselor in Asheville, North Carolina, and executive director of the non-profit Open Path Psychotherapy Collective. You can also search for the chapter of the National Alliance on Mental Illness (NAMI) in your area; staffers there may be able to connect you to providers.

Another search term worth trying: “sliding scale.” This means a therapist has a standard rate, but offers at least some slots at a lower fee for people who fall below certain income levels. You may have to provide some level of documentation about your financial situation, but doing so can result in a substantial discount.

“Many therapists consider it an ethical responsibility to see at least a couple of clients that are pretty low-fee,” Fugelsang says. His Open Path Psychotherapy Collective has gathered about 5,000 such providers who’ve pledged to offer treatment for \$30 to \$50 for individual sessions, after people pay a one-time, \$49 membership fee.

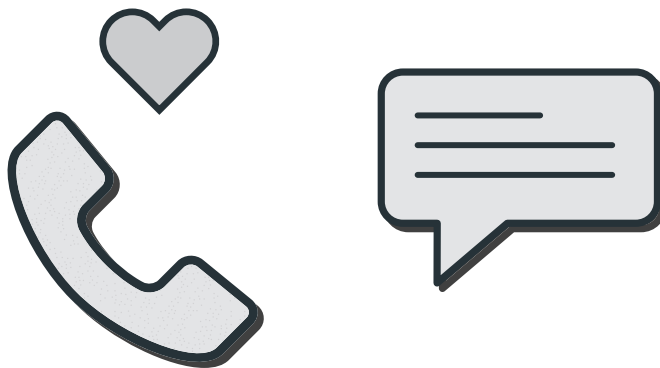
The site lets people search by ZIP code before they join—and the therapists don’t have to be as close

by as you might think. “Luckily the way it works in most states is that as long as the therapist and the client are sitting in the same state, it’s legal for the therapist to do online work,” he says. So even if you’re in a far-flung rural area, you can chat remotely with your therapist, a method he’s found works very well for many of his clients. You can also ask for recommendations for therapists from your doctor or from friends and family members you like and trust, then call to inquire about their rates and sliding scales, Alibrando says.

You can also call your closest hospital or university with a medical school or psychology department. Often, they’ll offer lower-cost or even free counseling with trainees or students. Of course, experience counts when it comes to therapists, says Sam Alibrando, a clinical psychologist in Pasadena, California. Experience, however, isn’t the only indicator of quality, he says.

In some cases, there may even be upsides to seeing a trainee, Kazez says. “Even if they have fewer years of experience doing the work, they’re also much closer to their education. They’re getting the most up-to-date education about how to do good counseling and they’re usually getting a lot more supervision and consultation than people who’ve been in the field for a while.”

■ I have really specific issues. Do I need to see a specialist?



If you're coping with common complaints like anxiety and depression, nearly any therapist will have training in how to guide you. If there's an added element to your experience, however, you might find free or low-cost resources through organizations that specifically focus on it, Alibrando notes.

For instance, RAINN (Rape, Abuse & Incest National Network) works against sexual violence and offers a free hotline at 800.656.HOPE (4673), among other services. The Anxiety and Depression Association of America offers a directory of low-cost providers, as well as advice on affording care when cash is tight.

If your mental health challenges are highly specific—for instance, post-traumatic stress disorder (PTSD) or eating disorders—you may want to start there to ensure you're finding someone specifically trained in those areas, Alibrando says.

Regardless of what lies at the root of your concerns, there are many ways to find help fast in a crisis. The National Suicide Prevention Lifeline provides free, confidential support 24 hours a day, 7 days a week via chat or phone (1-800-273-8255); or text HOME to 741741 to reach the Crisis Text Line. And if the situation's life-threatening, you can also call 911.

■ What are my other options?

In some cases, there's no substitute for one-on-one treatment from a mental health care provider. In other situations, however, different types of services can supplement or potentially even replace therapy. "There are a lot of options that aren't just sitting down with an individual therapist in one office that are often a lot cheaper and can be really powerful and helpful," Kazez says.

Group therapy, for instance, combines the guidance of a professional with connections to others dealing with similar issues. Programs such as Alcoholics Anonymous help many with substance use disorders. Religious organizations often offer faith-based counseling or support groups. Hospitals, clinics, or non-profit organizations may offer peer-to-peer support, a link to someone who's been through what you're going through, Kazez says.

■ What if I hate my therapist or can't afford to go anymore?

Sometimes, a given therapist's approach doesn't work for you—and every once in a while, you might run into a mental health care provider who just plain isn't good at what they do, Alibrando says. Or maybe you find a therapist you like only to discover, over time, that you can no longer afford their fees. Perhaps you've tried a few times and just don't think therapy's your thing.

That's OK—but that doesn't mean you have to give up on feeling better. "There are a lot of different ways to get help with your mental health, and help with your mental health doesn't have to mean therapy," Kazez says.

Group or peer-to-peer options, or even something as simple as joining an art class or sports team, might improve your mood, forge beneficial relationships, and help you learn communication and problem-solving skills. Or, try telling your therapist you'd like to come in once a month rather than weekly or biweekly, and ask them if they have a workbook they'd recommend—there are many evidence-based options targeting issues such as anxiety, depression, or anger.

And if things reach the point where your concerns are more serious or troubling, you can always resume your search. "There are absolutely ways to go about finding treatment and making it affordable," Kazez says.

■ What kind of health plan should I get if I need therapy?

Definitely one that covers mental health treatment—though again, most do, including all of them available on the Affordable Care Act marketplace. If you're choosing between different employer-based or public plans and already have a therapist, check to make sure that person's in-network, or that you can afford to pay the out-of-network rate if not. The provider's billing department can be a crucial source of information about whether one plan's better than another, so call them with questions before you make a final decision, Kimball suggests. If you're taking medication, also check that your prescription is on what's called "the formulary," or the list of drugs your plan will cover.

If you don't have a therapist yet, you might have to go through the process of scoping out networks and potential providers for each plan you're considering. Sure, it's a bit of a pain—but if there's a big difference between plans, it might end up saving you a substantial amount of cash.



■ Will my parents or employer find out if I go to therapy?



If you're on your parents' health insurance plan, they'll probably receive an explanation of benefits (EOB) or similar statement in the mail or online saying that you've been to therapy. But with a few important exceptions, such as plans to hurt yourself or others, everything you say to your therapist is confidential.

If your plan's through work, your bosses won't find out unless you tell them. Companies get big-picture information about the cost of employees' health care consumption, Kimball says. However, the specifics of your medical records—including the fact that you made therapy visits—are protected by what's called the Health Insurance Portability and Accountability Act or HIPAA. They can't be shared without your consent.

■ What happens if I need to take extended time off from work?

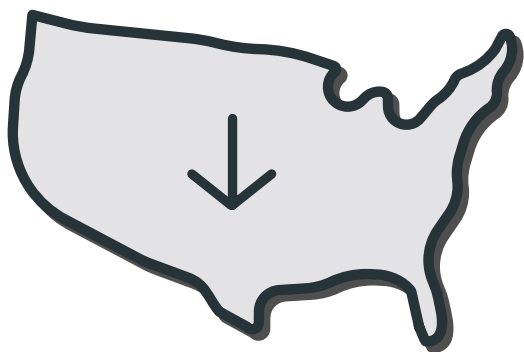
The same rules apply for mental health issues as for physical health problems. "They are both medical concerns that someone can approach human resources about to discuss extended leaves of absence, for example an FMLA leave like when someone is injured," Kazez says, referring to the Family and Medical Leave Act. (It's worth noting that, in most cases, only a certain percentage of your income may be covered—not all of it.) Your

therapist may need to provide documentation to your HR rep for time off, but at most companies, that person can act as a confidential go-between if you don't want to go into detail with your manager. And just as with any other health issue, if your employer doesn't provide reasonable accommodations, you can escalate things to higher-ups, get your provider involved, or possibly take legal action.

0004: HEALTHCARE IF YOU'RE A COLLEGE STUDENT

- 00001: HEALTHCARE: IF YOU'RE PREGNANT
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- 00008: HEALTHCARE: GLOSSARY

■ My school is charging me a student health fee. What does that cover? Do I still need insurance?



Yes, you still need insurance for things like emergency room care and services the health center doesn't cover. The student health center fee ensures that students who pay it have access to many health services on campus. (Most full-time students are required to pay this fee, if not, you'd have to pay per visit.) While some services, like routine doctor visits, vaccinations, or short-term counseling may be covered by this fee, others, like X-rays, prescriptions, or visits to specialty doctors, may

not be. The price of non-covered services will depend on your health insurance.

Look at the details about what's covered at your school and what's not—this should be outlined on the school website. (Side note: One benefit of the health fee, as explained later, is that it means you can use health services—mental health, too—and your parents won't know any of the specifics.)

■ What are the pros and cons of buying a plan my school sells?

We'll talk about your parents' insurance in a second, but first it's worth considering school plans. "Most major four-year colleges offer student health insurance," advises Erin Hemlin, the national director of training and consumer education at Young Invincibles, a young adult research and advocacy group. These plans usually count as qualifying health coverage to avoid the tax penalty.

It's likely you can use the school's health resources for things like check-ups or gynecological exams, STI screenings, treatment for illnesses, sleep issues, lab work/X-rays, regardless of having a student plan or not. The clinic may offer services on a sliding fee scale or for cheap, but find out what those costs are before you get sick, says Cheryl Fish-Parcham, director of access initiatives at Families USA.

However, the benefit of a student health plan is that they're often inexpensive and good quality, something that radically changed after the passage of Affordable Care Act (ACA). "Before the ACA, more than half the student plans were dangerous," says Stephen L. Beckley of Hodgkins Beckley Consulting LLC, a healthcare management and benefit consultant group that specializes in higher education. (Previously, many had "gotchas" like excluding coverage of pre-existing conditions, he says.) Today, luckily, things are different. "Student health plans can be exceptional value, even if you still have eligibility under your parent's employers plan," Beckley says. "It's not uncommon to hear from parents they're saving significant dollars going to a student plan." (Yes, you can stay on a parent's plan until age 26, but it's not free; more on that later.) Sometimes students are automatically enrolled in

student healthcare plans—and thus charged for them—unless they specifically opt out of coverage. For some schools that is true when it comes to full-time students, and you'll have to fill out a waiver to opt out. In other schools you'll go through an enrollment process where you either choose to enroll or waive coverage. Either way, it's not some sneaky system to insure you, Beckley says, but rather to make sure that you have a health plan in place. Anticipate what your health needs may be. Then, check out the Summary of Benefits Coverage to determine exactly what the plan covers and what the deductible is. (In schools that offer excellent health programs, this will easily be found on their website). Does it cover doc visits? Prescription drug coverage? X-rays? Lab tests? Vision and dental? And check out the coverage dates, if it's full-year, school year, or what happens if you're not enrolling until the spring semester.

Next, learn about what the copays are for medical and mental health visits at the Student Health Center and other in-network providers, as well as for emergency room visits. (While the campus health center may be the main resource, student health plans don't limit you to only campus care.) You'd need to compare these all of these costs—copays, deductibles, and premiums, or the cost of the plan—to whatever a parent's plan charges to find out if a student plan is truly a better deal.

Most school plans are also designed to cover you when you return home (even if it's in another state) or go abroad. "These often cover better than employer plans, providing worldwide coverage, including medical evacuation back home if you're in another country," Beckley says.

■ What do I do if I don't have the option of a parent's plan or buying a student health plan?

If your school doesn't offer insurance and getting on a parent's plan isn't an option for you, you can buy your own insurance. As Healthcare.gov points out, you can either get this on your own or be included on your parent's application if you're under 26. Most likely, you or your parents will sign up during Open Enrollment, unless they qualify for a special enrollment period for certain life events. For instance, if you lose student health insurance for whatever reason, get married, or have a baby, you can buy a Marketplace plan in a special enrollment window.

When you're shopping for insurance, Hemlin says to consider these three things: 1) What's the benefit package? Make sure the services covered are what you need—and what you anticipate you may need. Marketplace plans have to cover things like prescription drugs, mental health services, and maternity care, and, but you'll have to check to see if they offer additional benefits like dental or vision, or medical-management programs if you're treating specific conditions like diabetes. 2) Check out the network of providers. Can you actually access the doctors based on geography or your personal circumstances? If you're spending summers back home in one state and going to school in another, make sure there are providers in both areas. 3) Cost. If you're working part time and aren't eligible for insurance through your employer, you may

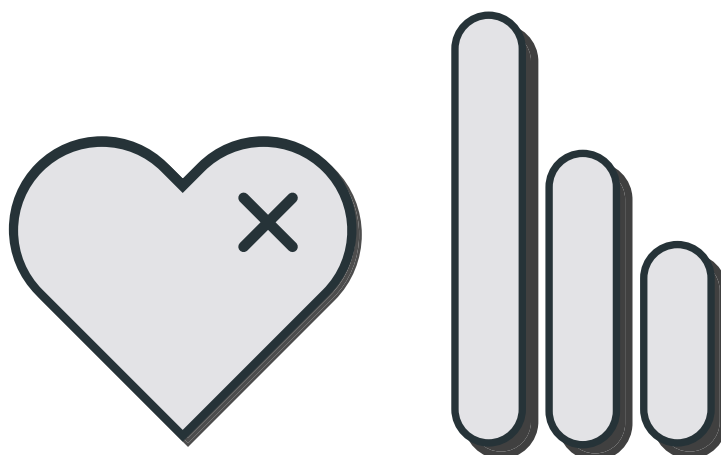
be able to get a discount plan. Or you may be able to qualify for Medicaid in your state if you can establish permanent residency.

As Hemlin points out, you shouldn't just go for the cheapest plan. "Even if you consider yourself young and healthy, we know people can get into an accident at any time and have to pay thousands of dollars in a deductible," she says.

That's why people are overwhelmingly enrolled in Silver Health Plans, a mid-range plan with moderate monthly premiums. You may also be able to save on out-of-pocket costs if you qualify for extra savings based on your income. These savings are known as "cost-sharing reductions" and basically they're a discount that lowers what you pay for deductibles, copays, and coinsurance—but only for silver plans, she says. Need help? Check out the Get Covered Connector tool from Young Invincibles, which will help connect you to local aids who can help you with your application.

This probably goes without saying, but if you're new to buying your own insurance, you want to make sure that you keep up with paying the premiums. If you have a break in payments (usually up to 90 days) and are dropped from your plan, you will have to wait until the next open enrollment period to get insured again, says Fish-Parcham.

■ I can't afford any of these options. I'll just have to risk it and be uninsured, right?



There are other ways to get covered. If you make less than \$16,573 a year (138 percent of the federal poverty level), you're eligible for Medicaid in more than 30 states as long as you're not a dependent on someone else's insurance, Fish-Parcham says. If you have Medicaid and your school is in another

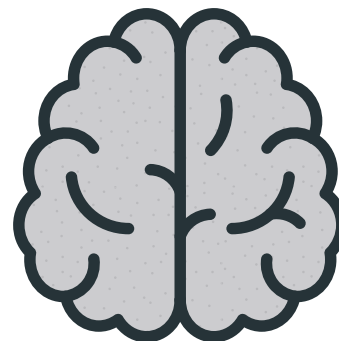
state, you may consider transferring Medicaid coverage to the other state, but first, consider if you're planning on going home during the summer and also look at what your new state's income guidelines are for Medicaid.

■ What about those cheap, short-term health plans that Trump approved?

Short-term health plans offer coverage for limited periods of time (three months), though Fish-Parcham says that new rules may make them available for longer. "We caution people to be very wary of these. They do not include mental health

coverage or sports injuries of the most part. There are many holes that would be especially problematic for a young person," she says. (They're already effectively banned in five states and restricted in others.)

■ What's the deal with mental health care on campus?



College may be the first time you're managing and responsible for your own health and mental health without involvement from your parents, notes Victor Schwartz, a clinical associate professor of psychiatry at the NYU School of Medicine and chief medical officer at The Jed Foundation, a nonprofit dedicated to promoting mental health and suicide prevention for teens and young adults.

"The demand for mental health care services is exploding. Having a student plan with strong long-term counseling is integral, but not all colleges offer this," Beckley says. Schwartz adds, "The most serious problems that emerge in students is more likely to be in the mental health arena, and these are fairly common. According to data from the National College Health Assessment, 40 percent say they experienced anxiety or depression significant enough to interfere with their functioning."

It's critical to know how and where to get support. Thing is, Schwartz adds, there is no national standard that enforces the type and availability of services on campus. Rather than assume what your school provides, you should just ask about their counseling services.

The benefit to getting counseling on campus is that "their services may allow you to see a practitioner sooner and with the same level of quality as in the local community," Schwartz says. The on-campus center can also coordinate with the school if you need specific accommodations or need to take a leave of absence for mental health reasons.

However, if you have an existing mental health issue, you should know that school resources are designed to provide short-term care, he says, meaning they're not intended for people who are already diagnosed. In that case, you should work out a plan with your current mental health team about how to best continue your care (where to go, how often, etc) before arriving on campus.

Ideally, the health center and counseling center at a university are integrated, Beckley says. "This is a standard in primary care that college health has been slow to adopt," he says, noting that Colorado State University, Cornell University, and the University of Minnesota are all examples of schools that provide excellent integrated care. Ask your school if that's the case and how these services work together.

■ What can I keep confidential from my parents even if I'm on their insurance?

If you're over 18, you're an adult. Know that health privacy and confidentiality laws protect your health and mental health records, according to a 2016 report from the National Alliance on Mental Illness (NAMI) and the JED Foundation. (The laws in question are the Family Educational Rights and Privacy Act, or FERPA, and the Health Insurance Portability and Accountability Act, or HIPAA).

There's an exception, though. If you use your parents' insurance to get healthcare, your parents will probably receive an explanation of benefits (EOB) that outlines which services were provided and how much the insurance company covered. Schwartz says this is one of the reasons most colleges charge student health fees rather than a fee for each health or counseling visit—if no bill is generated, then the visit can remain private.

But that privacy protection could work against you in certain cases. "These laws safeguard your information, but they can also prevent colleges from contacting your parents if you are facing significant challenges or a serious mental health condition," the report states.

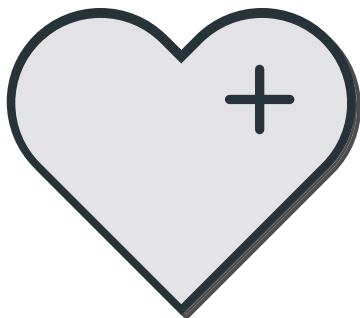
Before getting any type of care, it's a good idea to write directives out ahead of time by completing an authorization form that instructs providers when they can contact your parent or guardian about a health or mental health problem, Schwartz says.

Your school may have one of these forms available, but you can also find one on page 23 of the NAMI/JED report.

If you experience a health or safety emergency or mental health crisis, your provider can independently decide to communicate the issue with your parents, based on the severity of the situation, and also taking into account the climate at home. If the counselor has reason to believe that this information would be damaging to you if your parents were involved, then they may opt to not contact them. State laws can also kick in and prevent this communication, which is why you'll need to fill out that authorization form if you want your parents to be informed in case of emergency.

If your parent is worried about you and calls the counseling center asking if you've recently been seen (or, likewise, wants information from the health center), the school won't release that info without consent from you. They may instead speak to your parents in more general terms, e.g. that school health staff have been in contact with you and you are okay. That said, your parents can share any information with the school's health center or Dean of students that they deem helpful—like prescription medications and past treatment—and the school can "accept" it.

■ Should I really be considering healthcare when I'm choosing a school?



It may be too late to say this but, if you're still choosing a school (or will be next semester/year), consider the robustness of the health and counseling services when making your decision, Beckley says. "How well a college provides for health will vary dramatically from campus to campus, and it speaks to how they value the wellbeing of students," he says.

On campus tours, they should stop at the health center and emphasize the great services it provides. You can also get a feel for this by looking at a school's website, which should outline the student health benefits.

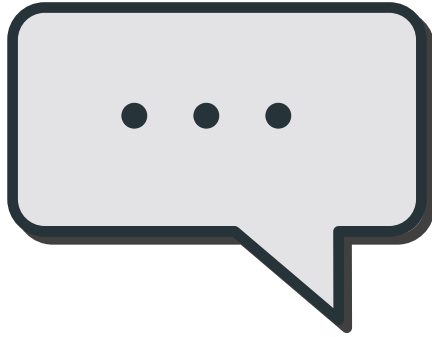
0005: HEALTHCARE IF YOU'RE ADDICTED TO OPIOIDS

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■ 00008: HEALTHCARE: GLOSSARY

- IS REHAB THE BEST, MOST EFFECTIVE TREATMENT FOR SOMEONE ADDICTED TO OPIOIDS?
- IS THERAPY ALSO NECESSARY? WHAT ABOUT OTHER SUPPORT?
- HOW DO I FIND A PROVIDER THAT'S COVERED BY MY INSURANCE?
- WHAT DOES INSURANCE HAVE TO COVER? DO THEY COVER IT WITHOUT A FIGHT?
- IS THERE A WAY TO AVOID GETTING CARE DENIED OUTRIGHT OR GET APPEALS APPROVED FASTER?
- ARE THERE THINGS I CAN DO NOW TO BE READY WHEN SOMEONE WANTS TREATMENT OR IF THERE'S A CRISIS?
- SHOULD I ALSO HAVE NALOXONE?
- WHAT ABOUT PEOPLE WHO DON'T HAVE INSURANCE OR THEIR COVERAGE ISN'T ENOUGH?
- ANY FINAL WORDS OF WISDOM?

HEALTHCARE IF YOU'RE ADDICTED TO OPIOIDS

■ Is rehab the best, most effective treatment for someone addicted to opioids?



The world of treatment for opioid addiction is upside down: The best treatments for cutting relapse and preserving life are stigmatized and relatively cheap, while less successful and more expensive residential approaches are featured as models in the press and on television programs like “Celebrity Rehab.”

“The layperson still typically assumes that addiction treatment is residential treatment and that’s a misconception,” says Sam Arsenault, director of National Treatment Quality Initiatives for Shatterproof, an addiction advocacy organization. Opioid use disorder (OUD) can often be treated effectively on an outpatient basis, she says, although residential treatment may be appropriate for some.

Regardless of the treatment setting, anyone seeking care needs to know this: methadone and buprenorphine (Suboxone), used long-term and in some cases for life, are the only two treatments proven to cut the overdose death rate by half or more.

Inpatient or outpatient rehabs that don’t permit the use of this medication or only use it short-term do not have this benefit—and these rehabs are less good at reducing relapse. A newer medication, long-acting naltrexone (Vivitrol) may help some, but it doesn’t have the proven, lifesaving results that the two other drugs do.

Consequently, if you or a loved one is seeking care and want the best odds of recovery, choose a program that uses methadone or buprenorphine long-term, not just for a week or two of “detox.”

However, if the person has only been addicted to opioids briefly or has other strong reasons for not wanting to start long-term use of one of these drugs, consider Vivitrol or drug-free programs that provide evidence-based psychological treatments like cognitive behavioral and motivational enhancement therapy. But the safest and most effective approach is to combine voluntary and appropriate psychological treatments with methadone or buprenorphine.

■ Is therapy also necessary? What about other support?

No, but it's advisable. For many, a critical part of treatment is addressing problems that may have led to the addiction. At least half of people with any kind of addiction have another mental illness and most have experienced childhood trauma. For opioids, particularly heroin addiction, these rates are even higher: 90 percent have had at least one trauma exposure and a third have post-traumatic stress disorder (PTSD).

Ideally, these issues should be appropriately assessed and treated—if they aren't, recovery is much less likely. However, if the only step a person is ready to take toward recovery is taking medication, that should be encouraged: Medications offer protection against overdose even if use of other drugs isn't immediately stopped.

Also keep in mind that treatment that is warm and welcoming is much more effective than

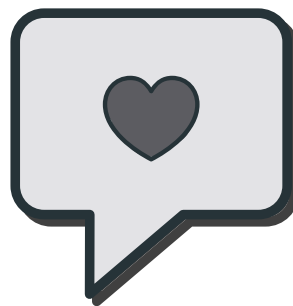
confrontational, coercive, or disrespectful counseling: Avoid authoritarian or humiliating programs. Calling the program and asking them about rules and discipline will usually unmask such providers; if something feels punitive, rigid or cold, avoid it if possible.

Since addiction is often chronic, it's important to plan for both ongoing care that reduces in intensity as the person recovers and, particularly, social support. This can take many forms: family, friends, 12-step groups, other self-help, gym memberships, volunteer work, church—basically, whatever the person finds most appealing and sustainable and keeps them occupied without substances. Exercise can be especially helpful as the “high” from exercise can help restore the brain's pleasure and motivation systems—if people engage in activities they actually enjoy. (Note, though, that you don't have to love every second of it.)

■ How do I find a provider that's covered by my insurance?

It's time to take a good look at your insurance documents and search their website for addiction treatment providers that are covered “in-network,” meaning they will be the least expensive.

“Rather than go through their insurer, many people go to Dr. Google and locate treatment that way,” Arsenault says. “That can result in a higher price tag.” Staying in-network will be cheaper and easier to get covered—go “out-of-network” only if you can't find care of sufficient quality.



■ What does insurance have to cover? Do they cover it without a fight?



This part is tedious but critical. “The great thing about the Affordable Care Act is that addiction treatment [must be] covered,” says Michelle Katz, a healthcare consumer advocate and nurse. The federal “parity” law, which is part of Obamacare, requires that no limits be placed on treatment for addiction and other mental illnesses that aren’t placed on coverage of physical illness. But the devil, of course, is in the details, which will vary from state to state and from insurer to insurer.

Consequently, reading your policy and learning about these details is essential. (You can find the covered benefits on your insurer’s website or in a document you probably stashed in a drawer and forgot about.)

In addition to the specifics on addiction care, the document will also include sections on what are known as “internal” and “external” appeals, or the processes to go through if (and when) a claim is denied.

“Many times, the first time you submit a claim, you will be rejected,” Katz says. You’ll need to know the nature of the appeals processes, which allows you to fight denial of coverage. If you’re denied, immediately demand a review, which will first be

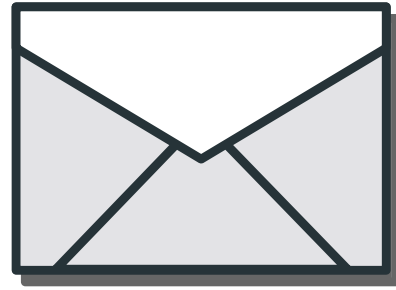
done by a doctor who works for the insurance company (internal appeal). If you lose in the internal review, go for an external review, which has to be done by a doctor who isn’t employed by the insurer.

Some insurers have “fail first” policies, which mean that people have to try less-intensive treatment and fail at it before more comprehensive care will be covered. This is less likely to be a barrier to getting medication treatment covered, but it is often used to fight against paying for inpatient care.

Consequently, be sure that inpatient care truly is the best option in your case if you are going to fight for it. For people who aren’t homeless and not living with drug dealers or in other dangerous environments, outpatient treatment can often work just as well. (If you’re convinced that a change of setting is necessary, a new safe living space far from known dealers and drug-involved friends doesn’t necessarily have to be in a treatment program).

Write down what you’re told in phone calls—immediately, so you don’t forget. (In many states, it is legal to record calls without the knowledge of the other party—and many insurers are already recording you as they state in their phone systems.)

■ Is there a way to avoid getting care denied outright or get appeals approved faster?



As you can probably tell already, dealing with insurance coverage for addiction is often a hassle. If you have a primary care doctor who knows you and is familiar with your insurer and the genuine need for treatment, that doctor may be your best weapon in the fight, according to Katz.

What you want to find is someone who knows the specific language to use in documenting the need for care that opens the door to coverage with that particular insurer. “You need to put language in the chart that emphasizes the desperation of the situation,” Katz says, “Ask for expedited approval because it is a life-threatening condition.” Given the overdose crisis affecting people with opioid addictions, this is not an overstatement—but it needs to be stated starkly.

Advocacy groups for families with addiction like Shatterproof and the Partnership for Drug-Free Kids have useful resources and can help connect you with others who’ve been there to help you fight your way through the system.

Depending on the state where you live, the attorney general’s office and the state agency that regulates insurance may also be helpful. Since these officials deal with bad behavior by insurers, they know the relevant state law and how patients can get the benefits they’re owed. The names of the agencies involved vary by state, but searching for “health insurance consumer protection” or “health insurance regulation” and the name of the state should bring them up.

While it’s almost never helpful to be impolite, it’s critical to be persistent. The more you complain and the more you show that you know what should be covered, the harder it is for insurers to deny benefits.

Bombard them with studies (some useful research is linked in the online version of this guide at [tonic.vice.com/healthcareguides](https://www.tonic.vice.com/healthcareguides)) that show what works to fight opioid addiction, call frequently, and let them know you aren’t going to stop until you or your loved one gets the treatment they need to get better. Endless paperwork and slow bureaucracy are huge deterrents to getting your claims paid, but don’t let it stop you.

■ Are there things I can do now to be ready when someone wants treatment or if there's a crisis?



Fighting to get the coverage you're owed can sometimes be a full-time job in itself—and this is hardly what a person with addiction or their family members need to deal with while in crisis or when a person who previously resisted help finally decides to go for it.

Consequently, try to do your research and have as much of the paperwork ready as possible (like medical and insurance records) before there is a crisis or recovery opportunity—either of which is hard enough to manage without having to deal with insurance companies.

■ Should I also have naloxone?

Regardless of where you or your family member is in the recovery process, keep the overdose antidote naloxone on hand—it's better to have it and not need it than it is to need it and not have it. Some insurers will cover this medication with no copay

and many harm-reduction programs distribute it and train people to use it for free. There's more info on how to get naloxone on tonic.vice.com and at hopeandrecovery.org.

■ What about people who don't have insurance or their coverage isn't enough?

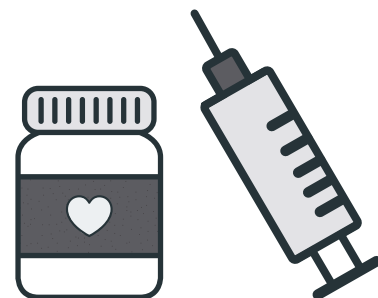
Most states have publicly funded treatment programs that are available to the uninsured, and nearly all treatment programs will also work to enroll patients in Medicaid so the facility can get paid for the care. Calling a treatment center that seems like a good fit and asking if this is an option at their facility is generally the best way to find out about these slots. Some private programs also have “scholarships” for people who cannot otherwise afford to attend; again, call and ask.

Be aware, however, that some rehabs and treatment programs will “balance bill” for services that aren't covered completely; people have been hit by surprise bills for thousands of dollars. Ask about exactly what is covered and what isn't, especially with regard to “scholarships.”

Further, don't pay any unexpected bill just because it is sent to you. Call and challenge it, and find out about your specific rights via your attorney general or insurance commissioner's office. In some states, it's actually illegal for programs to accept insurance payments and then bill the patient for more than the insurance rate for a given service. Your insurance will send you documents known as an explanation of benefits (EOB), which will spell out how much a provider is allowed to charge for a specific service. If the provider tries to bill you for more than the “allowable amount,” challenge it.

■ Any final words of wisdom?

America's medical system is not patient-friendly in general, and it is even less so when it comes to addiction. However, most people with opioid addiction do recover—provided they can avoid overdose. Always have naloxone, try to keep on top of your insurance coverage (both maintaining coverage and fighting for benefits), and reach out to organizations like Shatterproof and The Partnership for Drug Free Kids for support from others who have been there.



0006: HEALTHCARE IF YOU NEED AN ABORTION

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- 00008: HEALTHCARE: GLOSSARY

IF YOU NEED AN ABORTION

BY GARNET HENDERSON

So you're pregnant and don't want to be, or you have a wanted pregnancy but the fetus has a fatal anomaly or the pregnancy could threaten your health. Whatever the case, you want an abortion. Here's how to get the care you need.

■ How do I find the nearest abortion provider?

The answer may seem obvious, because you can Google that, right? But crisis pregnancy centers (CPCs)—fake clinics designed to look like abortion providers that actually exist to convince pregnant people not to get abortions—have gamed the Google maps system. They may appear first in search results, and may even claim to provide abortions.

CPCs also intentionally open near real abortion clinics, and even open up in spaces formerly occupied by abortion clinics. “I once visited a clinic in Jacksonville, Florida, and there’s a CPC right across the street. They used the very same language and font for their sign so they would look as much like the real clinic as possible,” says Oriaku Njoku, the co-founder and executive director of Access Reproductive Care–Southeast, an abortion fund. Njoku also recalled helping a caller from South

Carolina who was lied to by a CPC, where staffers told her she was only 12 weeks pregnant when she was actually 21 weeks along.

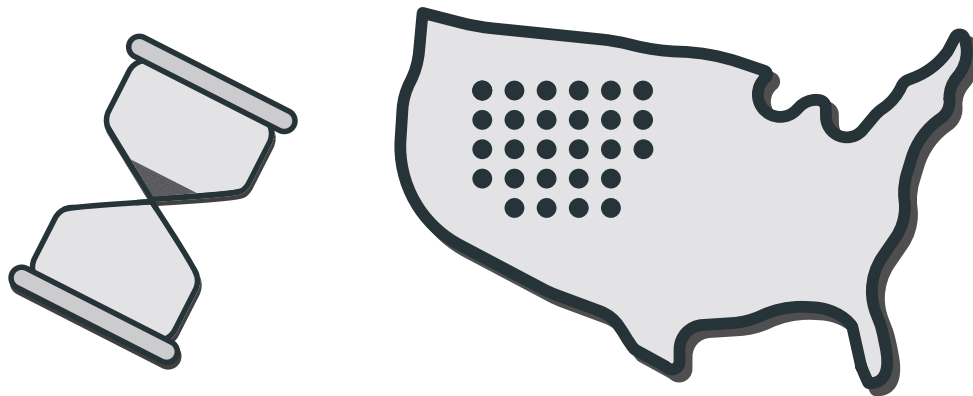
There are several ways to verify that a clinic is real in order to avoid being misled by a CPC. The National Abortion Federation (NAF) has a comprehensive directory of providers, and all Planned Parenthood health centers are listed online. However, just because a clinic isn’t a Planned Parenthood affiliate doesn’t mean it isn’t reputable—two-thirds of abortions are performed by independent providers. In addition to the NAF directory, many independent providers are members of the Abortion Care Network, which maintains its own list. Njoku also suggests contacting your local abortion fund, which can help you find a trusted provider.

■ Can my regular OB/GYN do it?

In some cases, especially in major cities, you may be able to go to your regular gynecologist or at least get a referral from their office. The latter is especially true in the case of a pregnancy that is nonviable or poses a risk to your health, as some providers are more willing to offer referrals in those instances. However, fewer than two-thirds of OB/GYN residency programs offer abortion training, and only a small number of OB/GYNs in private practice perform abortions. In many places, a specialized clinic with trained, experienced providers is the best option.

Despite evidence that advance practice clinicians (APCs) like certified nurse midwives, nurse practitioners, and physician assistants can safely provide abortions, 42 states mandate that only physicians can perform procedural abortions, and 34 allow physicians only to administer medication abortion, according to the Guttmacher Institute. California is the one state with a law on the books explicitly allowing APCs to perform

■ Is there a waiting period for getting an abortion?



Twenty-seven states have a waiting period—most commonly 24 hours—in between counseling and the abortion itself. Fourteen of these states require

that the counseling be done in person, which means you'll have to make two trips to the clinic. In other states, this counseling can be done over the phone.

■ What if I'm under 18?

Most states—37, to be exact—require some level of parental involvement in your decision to get an abortion if you're under 18. Most of these require parental consent, but 11 require only that parents be notified, and seven allow another adult relative (like a grandparent) to consent. Because the Supreme Court ruled that parents cannot have complete control over a minor's decision to get an abortion, most states have some way around these parental consent or notification laws. Usually this is done by judicial bypass, meaning you can ask a judge for permission to get an abortion without notifying your parents. Thirty-four of the 37 states

also allow people under 18 to get an abortion without parental involvement in cases of medical emergency, and 15 the 37 states allow people under 18 to get an abortion in cases of incest, abuse, neglect, or assault.

The Guttmacher Institute has a chart to help you figure out what the laws are in your state. Your provider or local abortion fund will also be familiar with state laws and may be able to help connect you with organizations like Jane's Due Process that help with the judicial bypass procedure.

■ What happens during the appointment?

At your appointment, a doctor or other health professional will take your medical history, vital signs, and talk to you about the options available to you. Most providers perform an ultrasound.

Many states require it, and some even require the provider to show and describe the ultrasound image, while others simply require that the provider offer to show you the image.

■ What happens during the procedure itself?

The vast majority (two-thirds) of abortions in the US happen at or before eight weeks of pregnancy. Early in pregnancy, you generally have two options: medication abortion or aspiration abortion.

Medication abortion, which is FDA-approved for use up to 10 weeks after your last menstrual period, involves taking two pills. The first, mifepristone, works by blocking the hormone progesterone, which is necessary to sustain the pregnancy. Between six and 48 hours later you take the second pill, misoprostol, which causes the uterus to contract and expel the pregnancy. Cramping and bleeding usually starts within one to four hours of taking misoprostol, and lasts for several hours after that. You could experience some intermittent cramping for one or two days afterward.

Because of FDA restrictions—which are currently being challenged by the American Civil Liberties Union (ACLU)—mifepristone, the first pill, has to be dispensed by a registered provider. (It's literally not available at retail pharmacies.) Nineteen states require that the provider hand the pill to you in person, meaning a telemedicine appointment is out of the question. Though many people prefer medication abortions because they can be done at home, medication abortion is a slightly longer process and usually requires a follow-up visit to make sure the termination is complete. If you live

in a state that bans telemedicine abortion, this means at least two trips to the clinic, and three if you live in a state that has a waiting period and requires in-person counseling.

Aspiration (or suction) abortion is usually done up to between 14 and 16 weeks pregnancy. In this procedure, the provider dilates your cervix and uses gentle suction to remove the contents of the uterus. This is usually done using a local anesthetic, though some clinics may offer additional anesthesia.

A dilation and evacuation, or D&E, is the most common procedure used in the second trimester of pregnancy. Because the cervix needs to be dilated further than for an aspiration abortion, the provider may start the dilation process the day before the procedure or earlier on the day of. The provider then uses suction and, if needed, other medical instruments to empty the uterus. D&E procedures are often, but not always, performed under some level of sedation. The D&E procedure is one of the latest targets of anti-abortion lawmakers, who have banned it in multiple states. Bans are in effect in Mississippi and West Virginia, but have been blocked by legal challenges in seven other states.

■ How far along in pregnancy can I get an abortion?

In *Roe v. Wade*, the Supreme Court held that abortion must be legal up to the point of fetal viability, and after viability if a woman's life or health is in danger. There is disagreement about when exactly a fetus is viable, but it is generally held to be around 24 weeks. Many states have laws on the books banning abortion at viability. Several now have laws banning abortion at 20 weeks postfertilization, or 22 weeks' gestation, based on the inaccurate claim that a fetus can feel pain at that point.

Numerous states have tried to ban abortion even earlier in pregnancy, and some of these cases could

make it all the way to the Supreme Court—which now has a 5-4 conservative majority thanks to Brett Kavanaugh's confirmation. Four states have laws that would immediately ban abortion if *Roe* were overturned.

Even though abortions in the second trimester are generally legal, the farther along you get in pregnancy, the fewer providers there are who will be willing or able to perform your procedure. Some providers only offer medication abortion or don't offer abortions after the first trimester because unnecessary regulations make later abortions too difficult to provide.

■ I have health insurance. Does that cover abortion?

That depends on what kind of insurance you have—and if you have to travel out of state for the procedure. Most employer-based health insurance plans provide coverage for abortion, but how much you'll end up paying will vary (more on that later). However, 11 states have laws that limit abortion coverage in all private (aka non-government) insurance plans, which is an umbrella term for plans you get through your employer and coverage you buy online. The 11 states that limit coverage in private plans are: Idaho, Indiana, Kansas, Kentucky, Michigan, Missouri, Nebraska, North Dakota, Oklahoma, Texas, and Utah. For many of them, the only allowable exception is if the mother's life is in danger.

Nine of those 11 states allow abortion coverage through the purchase of an additional rider, but very few riders are actually available for people to buy. "Abortion riders are really a bait and switch

that we see when states or federal policymakers are proposing bans on abortion. It's completely impractical. Most people are not planning ahead to have an abortion," says Megan Donovan, a senior policy manager at the Guttmacher Institute.

A whopping 26 states have abortion coverage restrictions specific to the health plans people buy through the Affordable Care Act online marketplaces. Some states do have exceptions, allowing plans to cover abortion in situations like rape, incest, or life endangerment. The Guttmacher Institute has a chart listing state restrictions for private insurance.

If you have a student health insurance plan, it may cover abortion. "Student plans are not governed by state laws. A state ban on abortion coverage doesn't necessarily mean that it impacts a student health plan," says Fabiola Carrion, senior staff attorney at the National Health Law Program.

■ I have Medicaid. Does government insurance cover abortion?



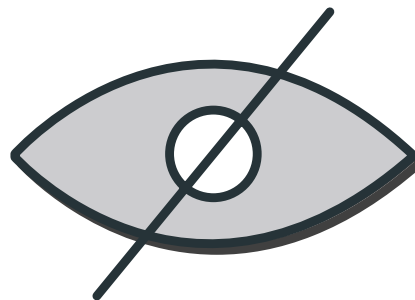
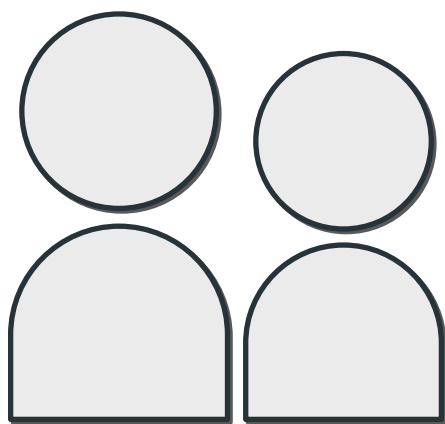
Most people seeking abortions are poor or low income, meaning they are more likely to be uninsured or have insurance through Medicaid, a government-run insurance program. Since 1976, the Hyde Amendment has blocked the use of federal Medicaid funds for abortion. Narrow exceptions were added later on, allowing coverage of abortion in cases of rape, incest, or life endangerment. (The Hyde Amendment isn't even a law: It's a rider that has been tacked on to every major spending bill since 1976.)

Medicaid is jointly funded by the federal government and the states, which means states can use their own funds to cover abortion. Seventeen states have such coverage policies in place—some by choice but most by court order. “Medicaid coverage [for abortion] is really only available in 16 states, because Arizona has a court

order but doesn't actually provide the coverage,” Donovan says. South Dakota only pays for abortions through Medicaid in cases of life endangerment, violating the federal standard by excluding rape and incest. Congress has control over Washington, DC, and has blocked Medicaid coverage for abortion there almost continuously since 1989.

Since the introduction of the Hyde Amendment, similar restrictions have been placed on health insurance plans other than Medicaid that are also offered through the federal government. This affects government employees, active military and veterans, Peace Corps volunteers, Native Americans, people incarcerated or detained in federal prison, and those with coverage through the Children's Health Insurance Program (CHIP). According to Guttmacher, 22 states also restrict abortion coverage for state employees.

■ What if I'm on a parent's or partner's insurance and I don't want them to find out about my abortion?



When you use your health insurance—whether you have coverage through an employer, a marketplace plan, or Medicaid—the insurance company sends a document, usually called an explanation of benefits or (EOB), to the policy holder explaining what the provider charged and how much insurance will pay for your care. This is a concern for many people seeking an abortion.

“Only four in 10 privately insured abortion patients use their insurance to pay for the procedure. For the other six in 10 who are privately insured but don’t use their coverage, it could be that they have a plan that doesn’t cover abortion, or the provider isn’t in network, or they have a high deductible, or that they don’t want to use their insurance. There are

confidentiality concerns given the stigma around abortion. People may be concerned that an employer, partner, or family member will find out,” Donovan says.

Federal law prevents your employer from accessing sensitive health information without your permission, so your employer won’t find about your abortion because you used your insurance. You can also ask your health insurance company not to send your parents or partner an explanation of benefits, or to send it to a different location. Unfortunately, federal law only requires them to honor that request if disclosing the information would endanger you. However, 13 states have put stronger protections in place, according to Guttmacher.

■ How much will I pay out of pocket?

If you don't have insurance, or aren't able to use your insurance, the average cost of a first-trimester abortion is around \$500, whether it's a medication abortion or an aspiration procedure. However, there are large variations from state to state and from clinic to clinic. "Generally, when you're between six and 12 weeks, the price is the same. But once you're 13 weeks, every week the price goes up," Njoku says. A second-trimester abortion may cost more than twice as much as a first-trimester abortion, or more. Abortion providers tend to be more transparent about cost than many other medical providers, and clinics will usually tell you up front how much they charge.

Unfortunately, even if you have an insurance plan that covers abortion, it may be difficult to figure out exactly what, or how much, is covered. "Right now, we're looking at the way in which marketplace plans describe abortion coverage [in the states where it's legal]. Plans are all over the place, from 50 percent cost sharing, to charging a \$250 copay, to subjecting the abortion to a deductible, and the

deductibles can be \$2,000 or more," Carrion says. That's right—sometimes it may be cheaper to pay for an abortion out-of-pocket than to use your health insurance.

Your local clinic is likely to be familiar with health plans in your area, and may be able to help you figure out what is covered. "We even give patients talking points sometimes to help when contacting their insurance companies," says Tristina Fitzpatrick, director of patient services at Allentown Women's Center in Pennsylvania. This kind of guidance can be very helpful because insurers can lack understanding about what an abortion actually entails, Carrion says. "If there is a difference in coverage between medication abortion and aspiration abortion, or second-trimester abortion, often that is not explained in the policy documents. Most plans consider abortion a surgical procedure, which means that patients end up paying more than they need to, and may be under the false impression that they're having major surgery," she says.

■ Can I use my HSA or FSA to pay for an abortion?

Yes, funds from a health savings account (HSA) or flexible spending account (FSA)—where you set aside money tax-free for medical expenses—can be used to pay for all or part of a legal abortion. (It's considered a qualified medical expense.)

■ What if I have to travel out of state—will my insurance cover it?

Sometimes, the nearest clinic is across a state line, or there's not a provider in your state that offers the procedure you need. Using insurance across state lines—whether private or public—is possible, but tricky. “One big problem is that an out-of-state provider is probably out-of-network. Depending on your insurance, if you're out-of-network, you

may have much worse reimbursement or none at all. Abortion providers often have trouble getting in-network in the first place,” says Adam Sonfield, also a senior policy manager at the Guttmacher Institute. So you can submit receipts to your insurance company, but you might not get much money back.

■ What about added costs like travel, childcare, and lodging?

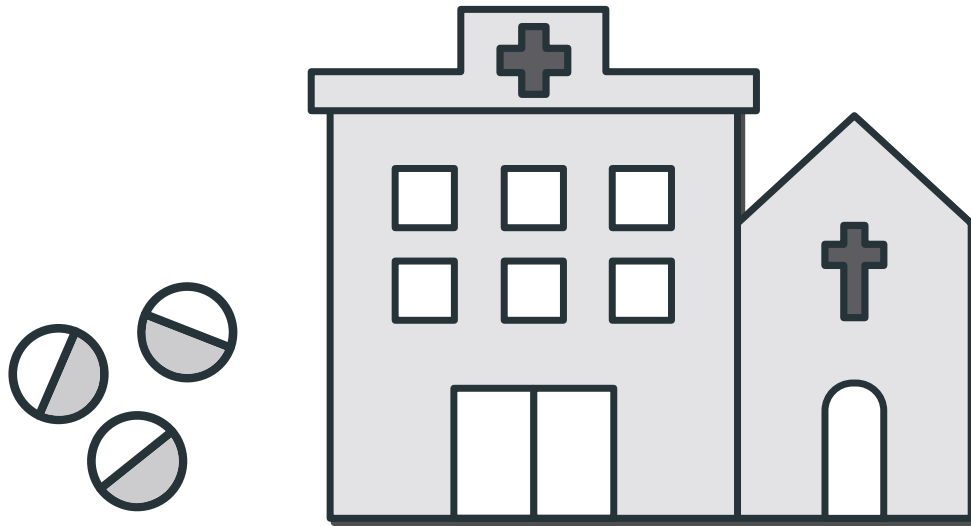
This is where abortion funds come in. Not only can they help cover the cost of the procedure itself, they can help with the additional expenses that now come along with abortion for many people.

“There are over 70 funds all around the country. We're all autonomous organizations and everybody does it a little differently,” says Njoku of Access Reproductive Care-Southeast. “We happen to have staff, other funds are run entirely by volunteers. Some funds have a hotline, and some funds have a cold line, where you leave a voicemail and they'll call you back.”

The staff or volunteers at an abortion fund will talk with you to get an idea of how much your abortion is going to cost you in total—not just what the clinic is going to charge. They will also ask how much you think you can realistically contribute, and offer what they can to help.

“There's no guarantee that we will be able to fully fund anything, but we'll do our best,” Njoku says. In addition to financial support, some funds have volunteers who help provide logistical support, like giving patients a ride to the clinic or providing childcare. Some clinics may also be able to help with these extra costs, Fitzpatrick says.

■ Do abortion restrictions affect miscarriage care?



Miscarriage care involves the same procedures as abortion. A doctor may prescribe you misoprostol (the second pill used in medication abortion) to help your body expel the pregnancy, or perform a vacuum aspiration, or, if you were farther along, a D&E. Bans on insurance coverage of abortion do not affect coverage for miscarriage, so if you have insurance you should be covered.

But you could still run into some problems. For example, a case in Arizona made headlines in June 2018 when a pharmacist refused to dispense misoprostol to a woman with a non-viable pregnancy that her doctor said would ultimately end in a miscarriage. A Michigan woman faced a similar issue in July 2018. Some states (and some pharmacies) require pharmacists with religious objections to have another pharmacist fill the prescription.

“Generally speaking, what happened in Arizona is rare. Catholic hospitals are a much bigger issue,” Guttmacher’s Sonfield says. “You don’t know if the hospital will treat you if they think what you’re experiencing is the aftermath of an abortion as opposed to a miscarriage. That is really hard to prove either way. And even if they believe it is a miscarriage, some of the ways in which the ethical directives for Catholic hospitals have been interpreted lead to truly substandard care for miscarriage and pregnancy complications.”

Unfortunately, it can be difficult to figure out a hospital’s policies regarding miscarriage and pregnancy complications. And, in many places, a Catholic hospital may be your only choice. At the very least, says Sonfield, you should be able to find out whether your local hospital follows Catholic hospital directives so you have an idea of what to expect.

0007: HEALTHCARE IF YOU'RE TRANS

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IF YOU'RE TRANS

BY GAINES BLASDEL

There is no one, correct way to transition genders or path to get there. Begin by talking it out with a trans and gender non-binary (TGNB) affirming therapist for a while? Great. Lead with hormones for six months and then see how you feel? Awesome. Start with chest surgery and a name change, then call it a day? Do you!

Regardless of what you feel your next steps are, the services you can access depend on where you live and insurance coverage. If you're feeling overwhelmed about figuring out where to begin, or just need a little help understanding the insurance aspect, trust that many other TGNB people have been in the same boat, and there are resources to help you.

■ Who decides if I'm trans or non-binary enough to get medical treatment?

At the end of the day, each surgeon or hormone provider makes their own choices about providing care. You might not need to see a mental health provider at all. The requirement for counseling has its roots in the university-based gender clinics of the 1960s and 70s, where a TGNB person would be tested and treated by a team of mental health providers before being deemed a “true transsexual” and granted (or, more often, denied) medical treatment.

The World Professional Association of Transgender Health (WPATH) formalized these early attempts to do TGNB medicine into a Standards of Care that gets updated periodically with changing times. The most recent version from 2011 has done away with many former requirements, like the “real-life test”

of first living publicly for a specific amount of time in your identified gender before obtaining medication and surgery.

The current Standard of Care even acknowledges that “informed consent” to start hormones is a perfectly reasonable way of doing things. This is when a primary care provider assesses if you're able to comprehend the risks and benefits of treatment without a mental health evaluation. Informed consent clinics are in many major metropolitan cities, but there are still geographic areas where the only providers who will prescribe TGNB hormones require you to get a referral letter from a therapist. Some therapists, including those who work across the US via Skype or other online platforms, may write these letters after a single appointment, depending on your mental health history.

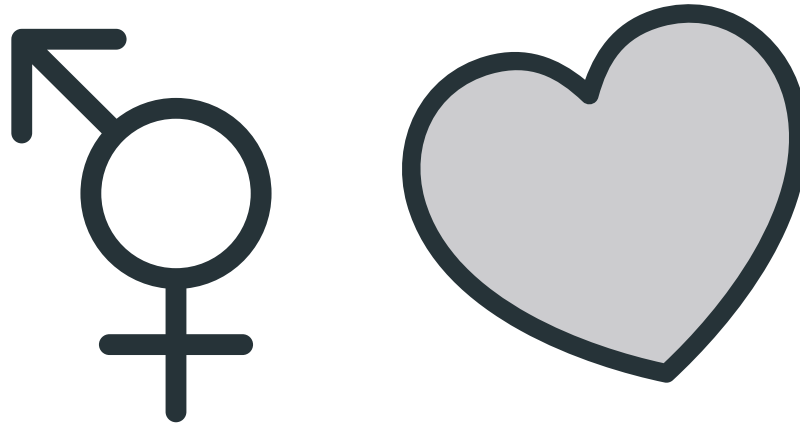
■ How do I find a therapist or medical provider?

WPATH maintains a directory of medical providers and therapists who are active members. Community organizers have set up a number of websites aiming to create provider directories. Word of mouth is another way to look for and vet providers, asking at in-person or online communities, like

groups on Reddit and Facebook, and at LGBT organizations that serve your area.

If you are in crisis and live in the United States or Canada, the Trans Lifeline (877-565-8860, translifeline.org) is one immediate resource.

■ I'm nervous about my first visit!



Sadly in 2018 it's still reasonable to be worried that a medical provider won't take you seriously, will actively discriminate against you, or will simply not know how to provide your TGNB-specific healthcare. A relationship with a medical provider is a partnership with shared decision-making and shared responsibility. A good provider will be happy that you're taking the initiative to get involved in your health, regardless of their own knowledge of TGNB care. If a provider discriminates against you by not offering services they would offer a cisgender (or non-transgender) person, it could be in violation of state and federal law, in addition to being in violation of professional ethics codes. If a provider is willing to learn how to provide for your TGNB-specific needs, you can point them toward online resources for medical providers to learn more.

On a path as individual as gender transition, even with the most TGNB-informed medical providers, you still have to speak up to get what you need. Aria Sa'id, senior policy advisor at the San Francisco Human Rights Commission and founder of the Kween Culture Initiative, encourages TGNB people to get behind the wheel of their own healthcare.

"We go into medical spaces believing that medical providers are the experts on our health, and unfortunately it just doesn't work that way. Really medical providers are able to, for lack of a better analogy, sell you the car, but you have to tune it up and you have to do oil changes and tire checks. You are the expert on your own healthcare, and your medical provider is just a guide to getting better."

■ Will my insurance pay for this?

Regardless of whether you have insurance through your employer or you bought an Obamacare plan, it will probably cover doctor's appointments, meds, and surgery, says Noah Lewis, executive director of Transcend Legal and a legal expert on TGNB healthcare. "There might be a denial or appeal process that you have to go through, but the law is on your side and you should feel empowered to demand the coverage that you are entitled to," he says.

Lewis is one of the movement experts using the patchwork of state and federal laws to expand access for those who have an insurance policy stating that TGNB care will not be covered. Starting in 1981 the federal program for seniors and disabled people Medicare was in this category. In 2014, however, a legal challenge to Medicare's policy was successful, and we have continued to see gains in coverage since.

Transcend Legal has an easy-to-follow video guide to using insurance to access TGNB care. Federal Medicare now covers TGNB care, as does Medicaid in many states. While movement advocates are working on policy and litigation that

we hope will ensure clear, national coverage, 10 states explicitly exclude TGNB care from Medicaid coverage and many private plans still carry blanket exclusions for TGNB care, according to LGBTmap.org.

The same considerations apply to using your health insurance for TGNB care as they would for any service. It is very common for requests for coverage to be given an initial denial, as Lewis notes, even if the policy says it is clearly covered. If your insurance approves the surgery or medication, it's important to know that there will still be costs like deductibles and copays built into the plan, unless you're on a version of state Medicaid. You may also be limited to in-network providers (doctors in a network that contracts with your insurance), or to services in your state if you have Medicaid. However, if your insurance covers a service but has no one in-network to provide the service, it is possible to claim a "network deficiency" to access another provider. And while it was once the most affordable option to fly overseas for surgery, if you're planning to use insurance, there is essentially no chance of being reimbursed for international care.

■ Do I need to change the name or gender marker listed on my insurance?

There isn't a blanket answer to this. In the course of my work as a case manager at Callen-Lorde Community Health Center in New York, I've seen billing hiccups happen both because the gender marker was changed and because it wasn't. Don't

delay changing your documentation now because of a theoretical problem accessing medical care later. Do check your insurance mail, and don't be afraid to pick up the phone (or have a bossy friend help you with the call) if you get into a billing headache.

■ Is there a risk that insurance coverage for TGNB care will get taken away?

With news of a Trump administration memo that, if put in place, would affect the way the federal government defines sex, many people are nervous about how it could impact TGNB health insurance gains. It's important to keep in mind that the federal government's definition of sex is not the only tool advocates have been using to expand TGNB coverage.

"When you hear [that] any day now that administration is trying to roll back the nondiscrimination protections under the Affordable Care Act (ACA), you should know that it's only a proposal, not the

law, and it might not go through," Lewis says. "There are many other laws that protect people, so it's a pretty minor thing. The ACA itself is still in place, you still have rights, regardless of what you hear in the news. There are many other laws and you should appeal denials and exclusions."

Other experts concur with his viewpoint while talking more specifically about the memo's possible reach. As we wait to see how this proposal will unfold, know that courts have continued to decide TGNB care must be covered.

■ What if I don't have insurance?

If you're trying to access primary care and medications, Federally Qualified Health Centers (FQHCs; search at findahealthcenter.hrsa.gov) and many public hospitals have sliding-scale fees for uninsured people, and they have access to government programs to make medications cheaper at their in-house pharmacies. It's also worth looking at GoodRx to see what the best prices are for your medications in your area. It might end up being cheaper to purchase insurance that covers TGNB care, especially if you expect to have bigger-ticket costs like surgery. Every year Out2Enroll reviews Affordable Care Act (ACA) marketplace plans in dif-

ferent states for TGNB coverage and they can help connect you to a TGNB-friendly health navigator in your state.

Some people also try to get a job at a company that's known to have TGNB-inclusive benefits, but it's still possible to experience an initial denial through any coverage. The key is understanding that it's a process, and as long as you keep on top of insurance mail and connect to one of the many advocates fighting for TGNB coverage (including Transcend Legal, Lambda Legal, and the ACLU) you should be able to come out the other end victorious.

■ What is the process like for getting transgender surgery?

Unfortunately, the historic lack of coverage in the United States has led to few trained surgeons and a lot of patients waiting to see them. Callen-Lorde Community Health Center, one of the largest providers of TGNB primary care in the country, published a listing of surgeons updated in 2018, including information about insurance coverage. Particularly for genital surgery, it's very common for surgeons to have waiting lists longer than a year, and the most experienced and reputable surgeons have waiting lists three years long. The waiting period can be used to get all your ducks in a row, insurance-wise, to be sure that everything goes well.

This is a boom period for new surgeons offering care in the United States, but not everyone has the same training and experience. Unlike in Europe and other countries that have been performing TGNB services in mainstream, academic medical centers for decades, surgeons in the US haven't been publishing peer-reviewed evidence about their outcomes and rates of complications until recently. There is no specific board certification or required training process that certifies surgeons offering TGNB surgery. For the time being, prospective patients need to ask careful questions, and at a certain point, go with their gut in the absence of hard data. It's best to consult with several surgeons before making a final decision.

Your surgeon and your insurance plan will likely require referral letters from mental health providers clearing you for surgery. The WPATH guidelines state that one letter is needed for chest surgery and two for genital surgeries, but insurance companies may pile on additional requirements beyond the guidelines. While this can feel like yet another hoop to jump through, ideally you'll have access to someone who can actually help you plan for the adjustment period to your new body that follows surgery, and serve as a resource after surgery if you encounter more problems than you expected. Some people experience depression after surgery, and it can be especially confusing and isolating to feel sad after you've finally gotten the procedure you've been waiting for. Set up a recovery plan, with a mix of professionals, family, and peers who can be in your corner.

You'll also need to save up to take enough time off work to recover fully. If you're eligible for the Family and Medical Leave Act (FMLA), it covers TGNB surgery leave. Additionally, any short-term disability coverage should cover leave for TGNB surgery. The paperwork to get these benefits could out you to your human resources department, but it doesn't have to. While the forms require your provider to make a statement of "relevant medical facts" regarding your need for leave, depending on the surgery, your provider may be able to find a way to describe your case without using language specific to TGNB care.

■ What about non-binary surgeries, surgeries sometimes considered cosmetic, voice surgery and surgeries for minors?

These surgeries have been covered by insurance in some contexts, including certain state Medicaid plans. While some plans explicitly deny that facial surgeries are a part of covered TGNB services, some individuals have fought their plans to argue for coverage. Even if your insurance says loud and clear these surgeries are covered, expect to have a harder time finding surgeons and a longer denial and appeals process. For something like Facial Feminization Surgery, your letters will need to make a persuasive argument that the procedure is

treatment for gender dysphoria, not a cosmetic improvement. Minors seeking all kinds of TGNB care mentioned in this guide, from hormones to surgeries, need to have their legal guardian's consent. For other services like fertility preservation, if it's not covered for cisgender people on the same plan, it is very unlikely you will be able to win coverage. If your plan does cover those services then TGNB people have a right to them, too.

HEALTHCARE GLOSSARY

BY SUSAN RINKUNAS

Let's be honest: Health insurance is confusing, so let's start at the beginning. Health insurance is a contract you buy that requires an insurance company to pay for some or all of your medical expenses. Some employers offer (heavily subsidized) insurance to their employees, some people buy their own plans, and the government provides insurance for older people as well as for low-income people and those with disabilities. Still, some people in the US go without insurance. To help you understand how it all works, here's a list of the terms you need to know, explained in plain English.

■ Affordable Care Act (ACA)

Really, its full name is the Patient Protection and Affordable Care Act (PPACA) and it was passed in early 2010 and fully implemented as of January 2014. It's also known as Obamacare, after the President who shepherded it and signed it into law.

People in the United States aren't guaranteed to get health insurance. They have to get coverage from their employer or spouse's employer, buy it themselves, qualify for a government program, or go without. The ACA sought to get more people covered by insurance and protect people from going bankrupt from medical bills. It did that in a few ways: It said young people could stay on their parents' plans until age 26, it expanded the eligibility requirements for Medicaid, and it banned insurance companies from discriminating against people for having preexisting conditions [see "preexisting conditions"], which range from having

given birth via C-section to having diabetes and other very basic, common things.

The ACA required insurance companies to cover everyone, and charge them the same rates no matter their health history. It also mandated that plans cover, at minimum, the same set of essential services [see "essential health benefits"], including preventive care at no cost, like vaccines and a set of benefits specific to women. The ACA also banned annual or lifetime caps on those essential services.

In 2010, 48.6 million Americans, or 16 percent of the population, didn't have health insurance. In 2017, the number of uninsured had fallen to 29.3 million people (or 9 percent of the US). That's still a sizeable chunk of people without health insurance, and that's why people want to improve upon Obamacare or replace it with universal coverage.

■ Annual and Lifetime Limits

These are caps on the benefits your insurance a company will pay in a given year or over a lifetime; after you hit the number, they stop paying and you're on the hook.

Annual limits can be dollar amounts or a number of visits. Obamacare banned annual and lifetime limits for a set of 10 essential health benefits. [see "essential health benefits"].

■ Coinsurance

The percentage of costs you have to pay for a service after meeting your deductible [see "deductible"]. Your plan will either charge a copay or coinsurance, not both. Coinsurance matters a lot if you see providers that aren't in your plan's network [see "insurance network"].

Say your copay for an in-network specialist is \$25 and your coinsurance for out-of-network providers

is 30 percent. If your therapist charges \$250 a visit and they take your insurance but are considered "out of network" (as is common with therapists), you'll first have to pay in full out of pocket until you hit your deductible, then pay \$75 a visit (30 percent of \$250) after that. If you see an in-network therapist, you'd owe a \$25 copay, and might not even have to pay the deductible first if your plan says office visits aren't subject to the deductible.

■ Copay

Short for copayment, it's a flat fee you pay for seeing a doctor or filling a prescription. Copays typically don't count toward your deductible [see "deductible"]. Usually you only pay a copay if you've already hit your deductible, but many employer plans cover things like office visits and trips to the emergency room before you meet the deductible and so, voila, you only get charged a copay. It's common to have different copays for primary

care providers and specialists, so you might pay \$25 to see a doctor about a suspected case of bronchitis and \$50 to see a specialist like a podiatrist.

There's usually an inverse relationship between your monthly premium (the cost of a plan) and your copays: Plans with lower premiums tend to have higher copays, and plans with higher premiums usually have lower copays.

■ Deductible

The amount you have to pay out of pocket for medical care before your plan will start footing the bill. Unfortunately, the deductible starts over every year. Many plans cover office visits before you've hit your deductible, so you may only have to pay a copayment for those visits rather than the full cost. After you've hit your deductible for the year, you usually only pay a copay or coinsurance for care [see "copay" and "coinsurance"].

Similar to a lot of employer plans, Obamacare

plans provide certain preventive health services for free, even if you haven't hit your deductible yet. These services include vaccines and certain medical tests for all adults, and a special set of services for women including birth control and an annual well-woman visit. (Contrary to popular belief, an annual physical with a primary care doctor is NOT one of the things that's required to be free, and it will cost you at least a copay. For many employer-sponsored plans, both the annual physical and also the well-woman visit are free.)

■ Essential Health Benefits

A set of ten services that all health insurance plans on the Marketplace [see "marketplace"] must cover as a result of the Affordable Care Act. Insurers also can't place annual or lifetime limits on these services. The ten categories are: doctors' services, pre-

scription drugs, hospitalization including surgery, outpatient hospital care, pregnancy and childbirth, emergency room care, mental health and substance use disorder services, laboratory services, rehabilitative services, and pediatric oral and vision care.

■ Flexible Spending Account (FSA)

If you have employer-based insurance, you can have money taken out of your paycheck before taxes and use it to pay for approved medical expenses including deductibles, copayments, and coinsurance. It's often loaded onto a prepaid card that you can swipe at a doctor's office or the pharmacy. You can

also use an FSA account to pay for other expenses like glasses, contact lenses, dental care, and health products sold on FSASTore.com, like bandaids, pain relievers, and sunscreen. In 2018, the most you could contribute to an FSA was \$2,650 a year, and you can roll over \$500 to the following year.

■ Health Savings Account (HSA)

This is similar to a flexible spending account (FSA) in that it's pre-tax money that can be used to pay for deductibles, copayments, and coinsurance. But you can only put money in an HSA if you have what's considered a high-deductible health plan (HDHP), which is generally any plan that has a deductible of at least \$1,350 for one person.

For 2019, you can contribute up to \$3,500 to an HSA for individual health coverage. Some insurance companies offer these accounts, or you can open one with a bank. And unlike an FSA, you can roll over the account's entire balance from year to year and the funds may earn interest, which isn't taxable.

■ High-deductible Health Plan

An insurance plan that requires you to pay at least \$1,350 out of pocket for an individual (or \$2,700 for a family) before the plan starts to pay its share, though the monthly premium (or cost of the plan)

is usually lower than plans with lower deductibles. Some plans sold on the insurance marketplace have deductibles over \$5,000 for one person.

■ Individual Mandate

This is one of the linchpins of the Affordable Care Act. In order for insurance companies in the Marketplace not to be saddled with only people who have preexisting conditions—people who buy health insurance because they need to use it and cost the insurance companies more money than people who don't require a lot of care—the law required everyone in the US to either have health coverage or pay a tax penalty.

Importantly, it doesn't say that everyone has to buy a plan from the ACA Marketplace, just that they need to have coverage that meets the law's minimum standards—so getting insurance through

work means you're good. The idea is that having "healthy" people in the pool of insured people helps keep costs down, but a lot of those people were mad that they suddenly had to get insurance. (Truth is, without insurance, healthy people are one accident or diagnosis away from big, big problems, physically and financially.)

Republicans effectively ended the individual mandate for 2019 in their tax bill. They couldn't erase it altogether, but they made the tax penalty for not having insurance \$0. Experts believe that healthier people will be less likely to buy insurance in 2019 and premiums for others will go up as a result.

■ Insurance Network

A group of providers and facilities that contracts with your insurance company to provide services at a discounted price. A doctor might accept your insurance and be considered in-network, and your insurance company will incentivize you to use providers like this by charging, say, a \$25 copay for

visits. Other providers may accept your insurance but are out-of-network and your insurance company may charge you more money to see them, for instance by subjecting the visit to your deductible and charging coinsurance, or a percentage of the cost rather than a flat fee.

■ Marketplace

The health insurance marketplace, also known as the "exchange," is the service available in every state that helps people shop for and enroll in health insurance. People who are buying their own coverage (i.e., not getting it through their job,

spouse, or the government) can shop for plans online, by phone, or in person. In most states, the federal government runs the marketplace and you sign up at [HealthCare.gov](https://www.healthcare.gov). But 11 states and Washington DC have their own sites.

■ Medicaid

A government-run insurance program that provides low- or no-cost health insurance to some low-income people, low-income or uninsured pregnant women and children, people with disabilities, the elderly, and more. People can apply for Medicaid at any time; it doesn't have to be during the open enrollment period

[see “open enrollment”]. Under the Affordable Care Act, more than 30 states expanded eligibility for Medicaid to include all adults below a certain income level—138 percent of the federal poverty level. (This is known as “Medicaid expansion.”) The states that have resisted thus far tend to be in the South and Midwest.

■ Medicare

A government-run insurance program for people 65 and older and some younger people with certain disabilities and conditions. Some politicians want to

make Medicare available to more people by letting them buy into it before age 65, aka a “public option,” or turn it into our nation’s one health insurance program [see “Medicare for all”].

■ Medicare for All

One way to achieve universal coverage is to make Medicare the insurer for everyone—not just people over 65 or people with certain conditions. Medicare allows both the government and private insurance companies to pay for care, so it’s not a single-payer

system. Vermont Senator Bernie Sanders has a plan that he calls Medicare for All, but if you want to get technical, his plan is actually single-payer healthcare because it would eliminate all private insurance companies, which isn’t how Medicare operates now.

■ Open Enrollment

The period when you can sign up for health insurance for the following year. Each employer has its own window, but for people buying their own plans, open enrollment has run from November 1 to December 15 the past two years in the 39 states that sell their plans on Healthcare.gov. (Most of the 11

states that run their own sites have longer enrollment periods.) You can sign up for or change your insurance outside of that period if you have what’s known as a qualifying life event. Examples include if you get married or divorced, have a baby, lose your health coverage, or if you move.

■ Out-of-pocket Costs

Also known as “cost-sharing,” this is the total of what you, not the insurance company, spend for medical care. It includes deductibles, copays, and

coinsurance, but not the monthly premium since that’s the cost of having insurance, not for getting care.

■ Out-of-pocket Maximum

Yes, there is a limit to how much the insurance company can make you pay in one year. After your out-of-pocket costs hit whatever that amount is, the insurance company picks up 100 percent of any

costs for covered services thereafter. And while copays don’t usually count toward your deductible, they DO count toward your out-of-pocket max.

■ Premium

The amount you pay just to have an insurance plan, even if you never set foot in a doctor’s office. If your insurance comes from your employer, the premium gets deducted from each paycheck

throughout the year. (This isn’t the true cost of the plan—your employer pays for some of it.) If you buy your own plan, you pay the insurance company directly every month.

■ Preexisting Condition

Before the Affordable Care Act, people who bought their own insurance could be denied coverage for having a preexisting condition like diabetes and Crohn’s disease. Some insurers would cover you if you had a preexisting condition, but they’d charge

you more than other people. The ACA banned insurance companies from asking people about their health history and required them to accept everyone and charge them the same rates.

■ Private Health Insurance Plan

A health plan that isn't "public," that is, paid for by the federal government. Private plans include those offered by employers and ones people buy

themselves. The majority of Americans have private insurance: In 2016, 49 percent of Americans had insurance through work and another 7 percent bought their own coverage.

■ Public Health Insurance Plan

A health plan that's operated by the federal government—so, Medicaid and Medicare.

■ Single-payer Healthcare

One type of universal healthcare. The payer in this case is the government, rather than a for-profit insurance company. A single-payer system would make health insurance companies obsolete: You'd get health coverage from the government and the

government would pay doctors a set price for medically necessary care. You, the user, would have no premiums or deductibles, but there would likely be some out-of-pocket costs, and not every country with single payer covers vision or dental care.

■ Universal Healthcare

A system that guarantees that everyone in a country, or even a single state, gets health insurance, no matter their ability to pay. The system is funded by taxes. There are several types

of universal healthcare, including single-payer, where the government pays for care provided by private companies (see: Canada), or socialized medicine, where the government pays for and provides the care (see: the UK).