A Patient’s Guide

Understanding Your Healthcare Benefits

Use this guide to find useful information about how health insurance helps you pay for treatment.
If you are like many people, you may be confused about health insurance and healthcare benefits. A benefit is something that is positive and usually helps you. It could be in the form of a payment for something, like education or a gym membership. A benefit could also be a free or reduced-cost service, like free bus transportation.

This guide aims to provide useful information about health insurance: how health insurance helps you pay for medical treatment. You will see that some words are printed in **black bold** type. Those are terms that could be unfamiliar to you. They are included in a glossary of definitions in the back. In this guide there is also information about the BMS Access Support® program, in case you have further questions.
Health insurance is a benefit that helps you pay for medical services and medications. It is like other types of insurance, such as car or homeowners’ insurance. You pay your health insurance company a certain amount of money on a regular basis.\textsuperscript{1,2} This fee is called a **premium**.\textsuperscript{1,2} In return, your health insurance company agrees to pay for a portion of your medical bills.\textsuperscript{1,3,4} In addition to your premium, you usually have to pay part of the other costs for your healthcare, including a **deductible**, **co-payments**, and **coinsurance**.\textsuperscript{2}

There are 2 types of healthcare benefits—medical and pharmacy—and they each cover different items.

**The medical benefit** typically covers physician and hospital services for things like visits to the doctor, drugs administered by doctors, hospital services and supplies, and some home health services.\textsuperscript{5}

**The pharmacy benefit** typically covers prescription drugs taken by mouth, and self-administered injectable prescription drugs that are used at home.\textsuperscript{5}

### Common types of health insurance

To understand what healthcare benefits your insurance company **covers** or pays for, you first need to find out what type of health insurance you have.\textsuperscript{4} In the United States, there are two types of health insurance—private and public.\textsuperscript{3,4}

**Private health insurance** refers to any **health insurance plan** you don’t get from the government. It is either sold directly to you by insurance companies, or can be a benefit you get from your workplace or union.\textsuperscript{4} Private health insurance can also be called “commercial insurance.” Since the **Patient Protection and Affordable Care Act (ACA)** became law in 2010, people who weren’t covered at work or by public health insurance can now buy health insurance from commercial companies through the **Health Insurance Marketplace**, also called the **Healthcare Exchange**.\textsuperscript{4}

With commercial insurance healthcare plans, if you pay higher premiums, typically you get more healthcare services and your insurance company will pay more.

**Public health insurance** is run by the government. Examples are **Medicare** and **Medicaid**.\textsuperscript{3,4}

The most common types of private and public health insurance are summarized on the next page.
### Medicare

**Medicare Part A**
A medical benefit that covers hospital-related services and certain other services and equipment

**Medicare Part B***
A medical benefit that covers medically necessary and preventive services, including doctor visits and drugs that must be given by a doctor

**Medicare Part C**
Medicare Advantage Plans—allow Medicare benefits through managed care plans; these plans may include both medical and pharmacy benefits

**Medicare Part D**
A pharmacy benefit that covers prescription drugs taken at home

*Medicare-eligible patients must enroll in Part B to receive Part B benefits.

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### Medicaid

Covers people with low incomes and some disabled people

Funded partly by the federal government and partly by individual states

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### Veterans Health Administration/TRICARE DoD (Department of Defense)

Covers people who are or have been in the military, including
- Veterans
- Active-duty service members
- National Guard and Reserve members
- Retirees
- Families of retirees

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These charts include the most common types of insurance; they do not include all types.
Understanding What Your Insurance Covers

Insurance companies have different ways of paying for medical services and drugs. Because of differences between plans, it is important to know which medical and pharmacy services are covered by your plan. For example, a lower-cost managed care plan may require you to use a network of providers who have agreed to charge less for services, while a higher-cost fee-for-service plan might allow you to get treatment from any healthcare provider. What your insurance pays for is usually explained in one of the following forms, depending on your health plan:

• Evidence of Coverage (EOC), which may also be called a Certificate of Insurance
  — This form is a legal document similar to a contract that provides the most important facts about your insurance, including the plan rules and what medical services and treatments are included or not included in your health plan. It is sometimes combined with the Summary Plan Description

• Summary Plan Description (SPD)
  — Employers who provide retirement benefits are required to provide an SPD. It will describe what services are covered and not covered, charges you will have to pay, such as a co-pay or coinsurance, and how to file a claim. You can request the SPD from your Human Resources department to find out more about your coverage
  — If you have Medicaid or other public health insurance, check with your program to see what your plan covers, and ask them for a summary of benefits and coverage document

Your insurance company will give you a health insurance card as proof of insurance. Doctors’ offices use this information to process your healthcare claims. Some cards include the co-pay costs you may need to pay for different services or drugs.
The amount you will pay for your treatment depends on your healthcare plan.

In addition to your monthly premium, plans usually have an annual deductible. A **deductible** is the amount of money you have to pay each year for covered services and treatments before your insurance company starts to pay for them. Different parts of your health plan may have their own deductibles for the year. In addition, you may have to pay a certain amount up front for each doctor visit or drug, called a **co-pay**.14,15

Instead of a co-pay, some health plans will only pay a certain amount of money for a claim (a bill for treatment) once your deductible is met. This can be called the **allowable amount**, or **reasonable** and **customary amount**. Some health plans limit the percentage of money that they have to pay for a service; usually to 80%. You would pay the other 20%. This is called **coinsurance**.16

Your summary of benefits will tell you exactly what you need to pay for: your premium, what your annual deductible is, co-pays, and your annual maximum out-of-pocket costs. Your maximum out-of-pocket cost is the most you will pay for covered services in a plan year before your health plan pays 100% of the costs of covered benefits.14
Many health plans require you to go through an approval process before starting treatment.

There are two common approval processes, known as precertification and prior authorization. Your doctor’s office staff can help you with both of these approval processes. These steps may be needed throughout your treatment.

For treatment approval, your doctor’s office or hospital may ask for the following basic information about you:

- First and last name
- Gender (male/female)
- Date of birth
- Daytime phone number
- Address
- US citizenship or legal residency (yes/no)
- Social Security Number

### Precertification

If required, your doctor’s office staff gets approval for a healthcare service, like a non-emergency surgery, before providing the service.16

### Prior authorization (PA)

If required, your doctor’s office staff provides the health plan with your medical history, diagnosis, and treatment plan to show that the treatment they chose for you is medically necessary and will be used correctly.16,17

If you have more than one health plan, the staff at your doctor’s office will need to determine which plan will pay first (primary health insurance) and which will pay second (secondary health insurance).
You can use the checklist below to ensure that you give your doctor all of the information he or she needs to have about your insurance coverage.

<table>
<thead>
<tr>
<th>INSURANCE CHECKLIST</th>
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</thead>
<tbody>
<tr>
<td><strong>Primary/Secondary Insurance Information</strong></td>
</tr>
<tr>
<td><strong>Primary insurance company</strong></td>
</tr>
<tr>
<td>✔ Plan name</td>
</tr>
<tr>
<td>✔ Subscriber number</td>
</tr>
<tr>
<td>✔ Group number</td>
</tr>
<tr>
<td><strong>Secondary insurance company</strong></td>
</tr>
<tr>
<td>✔ Plan name</td>
</tr>
<tr>
<td>✔ Subscriber number</td>
</tr>
<tr>
<td>✔ Group number</td>
</tr>
</tbody>
</table>

If you have Medicare coverage:
Check all that apply:
✔ Part A  ✔ Part B  ✔ Part D
✔ Medicare Part C (Medicare Advantage)
✔ Medicare policy number
✔ Effective date

If you have Medicare Part D or Medicare Part C (Medicare Advantage), you may need to provide the following information:
✔ Insurance name
✔ Phone number
✔ ID/policy number
✔ Policyholder
✔ Primary/secondary insurance information
✔ State, veteran, or other plan
If you have more than one health plan that covers the same benefits, the Coordination of Benefits form you receive from your health plan will tell you which health plan will pay first. If one of the plans is a Medicare health plan, federal law may decide which plan pays first. The amount that each plan pays is based on your insurance coverage.\textsuperscript{18}

The Coordination of Benefits form you receive from your health plan will tell you which plan is your primary health plan—the one that pays first. The other plan is your secondary health plan—the one that pays second.\textsuperscript{18}

Your doctor’s office staff can work with your health plans to coordinate your benefits on your behalf. The table below explains how Medicare works with other health insurance plans.

**KNOW WHO PAYS FIRST\textsuperscript{18}**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Who Pays First</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have retiree insurance (insurance from former employment)</td>
<td>Medicare pays first.</td>
</tr>
<tr>
<td>If you’re 65 or older, have group health plan coverage based on your or your spouse’s current employment</td>
<td>Your private health plan pays first.</td>
</tr>
<tr>
<td>The employer has 20 or more employees</td>
<td>Medicare pays first.</td>
</tr>
<tr>
<td>The employer has fewer than 20 employees</td>
<td>Your private health plan pays first.</td>
</tr>
<tr>
<td>If you’re under 65 and disabled, have group health plan coverage based on your or a family member’s current employment</td>
<td>Medicare pays first.</td>
</tr>
<tr>
<td>The employer has 100 or more employees</td>
<td>Your private health plan pays first.</td>
</tr>
<tr>
<td>The employer has fewer than 100 employees</td>
<td>Medicare pays first.</td>
</tr>
<tr>
<td>If you have Medicare because of End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)</td>
<td>Your private health plan will pay first for the first 30 months after you become eligible to join Medicare. Medicare will pay first after this 30-month period.</td>
</tr>
</tbody>
</table>

**Important:** In some cases, your employer may join with other employers or unions to form a multiple employer plan. If this happens, only one of the employers or unions in the multiple employer plan has to have the required number of employees for the group health plan to pay first. For more information, contact your employer or union benefits administrator.\textsuperscript{18}
After you receive treatment, your health plan will send you an EOB or MSN. The MSN is a summary of Medicare Part A– and Part B–covered services. These statements are not bills. They are records of the services you received. They will tell you how much your treatment or care costs, how much your plan will pay toward those costs, and how much you may need to pay. Your EOB or MSN will also tell you if services aren’t covered by your health plan.

The EOB or MSN is an important document to use if you disagree with your plan’s decision on your claim. Sample EOB and MSN forms are shown here:

There may be times when your health plan denies coverage (refuses to pay) or underpays (pays less than what is needed) for a bill (or claim) for a certain treatment. Your health plan should let you and your doctor know in writing if this happens. The plan must also explain the reason for the denial and tell you how to file an appeal.

Usually your doctor’s office staff will file the appeal for you. But there may be times when you need to get involved or you may want to file the appeal yourself. You have a right to do this under the law.
The way a medicine is given can affect the amount of money you may have to pay out-of-pocket. Medicines taken by mouth (oral drugs) are covered differently from medicines that have to be injected. Especially with Medicare, you may have to make arrangements to receive and pay for each drug separately, if your treatment consists of 2 or more drugs.

Planning ahead for insurance coverage

Following your diagnosis, your healthcare team will explain how each drug you are prescribed is given to you and how often you may have to take it.

Each drug you take may:

- Be given differently, and therefore covered differently
  — For example, it may be a pill or liquid that is swallowed at home, a liquid that is infused into a vein in a clinic, or a liquid injected under the skin at home or in a doctor’s office

- Require special permission or approval from your insurance plan

- Require different amounts of cost-sharing (co-pays or coinsurance)
  — Depending on which parts of your health plan are providing coverage, and what benefits your plan provides, each drug your doctor prescribes may have its own co-pay and coinsurance costs
Coverage for Oral Drugs

Specialty pharmacies provide certain drugs and patient support services (for example, education and monitoring) that may not be available in your local drug store. Often, you don’t need to pick up your medication in person. Instead, it can be mailed directly to your home, and a pharmacist can provide advice and support to you on the phone.\(^{25}\)

If you are prescribed an oral drug, you will take this drug by mouth. No doctor’s appointment is necessary to take this medication. You may need to get the drug through a **specialty pharmacy**.\(^{25}\)

How is your oral drug covered?\(^7\)

Coverage for oral drugs is usually included under prescription drug benefits. For people on regular Medicare, prescription drug coverage is through one of the many Medicare Part D plans available. You can also have prescription drugs covered by a Medicare Part C (Medicare Advantage) health plan. There are many different Part C and Part D plans available. As with commercial health plans, some cover a greater portion of your drug costs than others, but may have higher monthly fees.

What will you pay for each oral drug?

Under Medicare Part D plans, you pay a separate co-pay and/or coinsurance for each drug you are taking, after you pay the deductible (if your plan has one) for the year.

If you have commercial prescription drug coverage (that is, none of your drug coverage is from Medicare, Medicaid, or other government-funded health plans), you may be eligible for a co-pay assistance program. These programs are available for some drugs and are offered by drug manufacturers.

If you have Medicare, Medicaid, or another government-funded health plan, no direct co-pay assistance is available. However, if Medicare considers you to be a low-income patient, you may be eligible for **Extra Help** or “low-income subsidies.” These subsidies help you pay for your out-of-pocket costs, and the amounts depend on your income.\(^7\)
Medicare Part D coverage for oral drugs and the donut hole

If you are prescribed oral drugs and you have a Medicare Part D plan, you will pay part of the cost of covered oral drugs and Part D will pay part. These amounts will change over the year depending on which phase of your drug benefit you are in. (See the diagram below for an example.)

- Before Medicare pays, you first must meet your annual deductible amount, up to $415 in 2019. After your total out-of-pocket costs for your prescriptions reaches the deductible amount, you will be in the initial coverage period. During this period, you will pay 25% of the cost of your prescriptions, until reaching the beginning of the coverage gap, known as the "donut hole." In 2019, the initial coverage period ends after a total amount of $3820 has been spent by you and your Part D plan.
- If you qualify for Extra Help, you will pay no more than $3.40 for each generic drug and $8.50 for each brand-name drug.

Closing the coverage gap

In past years, the donut hole was a big hole in the sense that patients needed to pay a large portion of their drug costs. Part D participants needed to pay about 40% of their drug costs during the coverage gap, which lasted until they spent a much larger total of out-of-pocket costs. But this year, the gap has narrowed. The upper out-of-pocket spending limit has dropped, and the percentage that patients are required to pay for drugs has dropped, too. Not everyone will reach the coverage gap, and people receiving Extra Help or low-income subsidies won’t reach the gap.

- In 2019, the coverage gap has closed for brand-name drugs. You’ll pay no more than 25% of the cost of brand-name drugs—the same amount you would pay in the initial coverage period. The coverage gap for generic drugs still exists, so you will be responsible for 37% of the costs of generic drugs once you’ve entered the gap.
When you have spent a total of $5100, you will be past the donut hole. Now you are covered by what Medicare calls “catastrophic” or very high levels of coverage for the rest of your treatment during the year. Under catastrophic coverage, in 2019, you will pay the greater of 5% of the remaining total cost of oral drugs, or $3.40 for each generic drug and $8.50 for each brand-name drug. The rest of the cost will be covered by Medicare and the Part D drug plan.
What you pay under Part D plans

Part D plans vary in terms of their specific benefits, costs, cost-sharing, and deductibles. For example, in 2019, 71% of Part D plans will charge a deductible, but only about half (52%) will charge you the maximum allowable deductible amount of $415.27 Not everyone will enter the Part D donut hole. Here are 2 scenarios showing how much you might pay and how much Part D might pay, depending on the drugs you take.

**Situation:** You have high blood pressure and high cholesterol. Your doctor prescribes 2 medications for your high blood pressure and 1 medication for your high cholesterol. You have a Part D drug plan that has a low premium and offers the standard Medicare drug benefit, including a deductible ($415) and standard drug coverage in the donut hole. Below and on the right are 2 examples of what your prescription drugs will cost you.

### EXAMPLE 1: COSTS REMAIN BELOW THE THRESHOLD FOR THE “DONUT HOLE”*

<table>
<thead>
<tr>
<th></th>
<th>You pay</th>
<th>Medicare covers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$415</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Initial coverage period:</strong> You pay 25% coinsurance of $1385 (costs remaining after deductible)</td>
<td>$346.25</td>
<td>$1038.75</td>
</tr>
<tr>
<td><strong>“Donut hole” gap and catastrophic coverage:</strong> Total costs are under $3820, so you will not go beyond the initial coverage period</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>TOTALS</strong> (covering $1800 total cost for the year)</td>
<td>$761.25</td>
<td>$1038.75</td>
</tr>
</tbody>
</table>

*COSTS do not include premiums for the Medicare Part D plan.

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3 brand-name medications that together cost $1800 for the year.
### Example 2: Costs Extend into the “Donut Hole” Gap*

<table>
<thead>
<tr>
<th></th>
<th>You pay</th>
<th>Medicare covers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$415</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Initial coverage period:</strong> You pay 25% coinsurance of $3405 ($3820 initial coverage maximum total costs minus $415 deductible already paid)</td>
<td>$851.25</td>
<td>$2553.75</td>
</tr>
<tr>
<td><strong>“Donut hole” gap:</strong> For your brand-name drugs, you pay 25% coinsurance† of $680 (total costs remaining after deductible and initial coverage period)</td>
<td>$170</td>
<td>$510</td>
</tr>
<tr>
<td><strong>Catastrophic coverage:</strong> Total costs are under $5100, so you will not go beyond the donut hole gap</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>TOTALS</strong> (covering $4500 total cost for the year)</td>
<td>$1436.25</td>
<td>$3063.75</td>
</tr>
</tbody>
</table>

*Costs do not include premiums for the Medicare Part D plan.
†Any generic drugs would have a coinsurance of 37% while in the donut hole gap.
If you are prescribed a drug given by intravenous (IV) infusion, it will most likely be given to you either in a hospital clinic or at your doctor’s office. 

Many drugs are given by IV infusion because this is the most rapid way to get a drug into your bloodstream. Other drugs you are taking—or even vitamins and herbal supplements—may prevent the treatment from working effectively. Before your first infusion, please make sure you ask your doctor what other drugs or supplements you may take while you are under treatment.

How is your IV infusion covered?
Coverage for IV infusions is usually included in a health plan’s medical benefits instead of pharmacy benefits. This is because these drugs are usually given at a doctor’s office or clinic. Private insurance coverage would be similar to public insurance, depending on the type of health plan you have—unless you have original Medicare, with Part D coverage. As an example, if you have original Medicare and you receive your IV infusions at a doctor’s office or clinic, your infusions would be covered under your Medicare Part B coverage. However, if you receive your IV infusions while you are admitted to a hospital, these infusions would be included in your Medicare Part A coverage because IV drugs are not covered under Medicare Part D.

What will you pay for each IV drug?
Each private plan is different when it comes to your out-of-pocket costs for treatments and procedures. Typically, you will pay a co-pay or coinsurance for the visit when you receive your infusion. There may or may not be additional fees for the infusion itself. You may be eligible for co-pay assistance programs offered by drug manufacturers for some drugs. If you are enrolled in Medicare Part B with no extra insurance coverage, you will be responsible for 20% coinsurance for each drug and 20% for each infusion, after the annual deductible is paid.

- If you choose to sign up for supplemental Medigap-type coverage for additional benefits, however, you may pay $0 for the drug and $0 for the infusion, after the deductible is paid.
  - A large majority (almost 90%) of Medicare patients have some type of additional insurance such as Medigap (or a similar plan), which reduces the out-of-pocket costs for office-administered drugs such as infusions.
Some drugs can be given as **subcutaneous (SC) injections**, almost like a vaccination, either at home or in the doctor’s office. Injections can be covered by either medical or prescription drug benefits (such as Medicare Part B and Part D), depending on whether they are given in your doctor’s office or at your home.7

**What will you pay for each SC injectable drug?**

If you get your SC injections at your doctor’s office, you will have the same co-pays and coinsurance as you would for an IV infusion, described on page 18. If you give yourself the SC injection at home, then the coverage is the same as for an oral drug [see Coverage for Oral Drugs section].
A Medicare example: coverage of 2- or 3-drug treatments that include both IV and oral drugs

If your doctor prescribes a treatment consisting of both IV infusions and oral drugs, remember:

- Drugs given by IV infusion will fall under your medical benefits (such as Medicare Part B), and
- Oral drugs will fall under your prescription drug benefits (such as Medicare Part D)
- Each drug must be obtained separately and has different co-pay and coinsurance requirements (See the table below.)

### FACTS ABOUT IV AND ORAL DRUGS IN ONE REGIMEN

<table>
<thead>
<tr>
<th>IV Medical Benefits or Medicare Part B</th>
<th>Oral Pharmacy Benefits or Medicare Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How drugs are covered</strong></td>
<td></td>
</tr>
<tr>
<td>Considered medically necessary by your doctor and approved by the Food and Drug Administration⁶</td>
<td>Must be listed on the approved drug list of your pharmacy benefits or Part D drug plan. This is called a <strong>formulary</strong></td>
</tr>
<tr>
<td><strong>Where you get the drug</strong></td>
<td></td>
</tr>
<tr>
<td>From the doctor’s office or infusion clinic⁶</td>
<td>Usually from a specialty pharmacy. (Some oral drugs may be available at your local pharmacy)²⁵</td>
</tr>
<tr>
<td><strong>Health plan management</strong></td>
<td></td>
</tr>
<tr>
<td>Doctor must have permission from the health plan or use drugs on the plan’s formulary first</td>
<td>Doctor must receive permission from health plan and/or use a formulary drug first. The number of pills you may receive at any one time may be limited⁷</td>
</tr>
<tr>
<td><strong>Cost to patient</strong></td>
<td></td>
</tr>
<tr>
<td>For patients who have Medigap insurance, the cost may be $0. For patients with Part B alone, the cost is 20% coinsurance for drug and infusion, after deductible is paid for the year⁷</td>
<td>Depends on health plan requirements, but “benchmark plans” for no premium are available for people receiving Extra Help²⁹</td>
</tr>
</tbody>
</table>
What if your Medicare Part D drug plan will not cover your medication?

- Medicare Part D drug plans are run by private insurance companies. Each private company has to follow Medicare’s rules for drug coverage, but each has its own set of rules, restrictions, and co-pays.
- However, you have the right to file an appeal if your Medicare drug plan will not cover a drug, or covers the drug at a higher cost than you think you should pay.
- You can ask for a **coverage determination**, which is a written explanation of your drug coverage benefits.
- You or the doctor who prescribed the medication can ask for an **exception** if:
  - You need a drug that is not on your plan’s list of covered medications
  - You believe that you should pay less for a more expensive drug because you can’t take any of the less expensive drugs for the same condition.

Talk to your doctor if you have questions about drug coverage or filing an appeal. Medicare has information on how to file an appeal at [www.medicare.gov](http://www.medicare.gov).
BMS Access Support from Bristol-Myers Squibb can help identify programs that may be able to help you manage the cost of your treatment. Your eligibility for these programs depends on what type of insurance coverage you have.

- **For patients with private (commercial) insurance**
  - BMS drug co-pay assistance programs may be available

- **For patients with public health insurance**
  - BMS-sponsored co-pay assistance programs are not available for patients with public health insurance
  - However, BMS Access Support can help refer patients to an independent foundation that may offer support based on individual needs

- **For patients without prescription drug coverage**
  - BMS Access Support can make a referral to independent charitable foundations that may be able to provide financial support, including the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF)
  - BMSPAF is a charitable organization that provides free medicine to eligible uninsured patients who have an established financial hardship. To learn more about BMSPAF, please visit [www.bmspaf.org](http://www.bmspaf.org)

- It is important to note that these charitable foundations are independent from Bristol-Myers Squibb Company. Each foundation, including BMSPAF, has its own eligibility criteria and evaluation process

- Bristol-Myers Squibb cannot guarantee that a patient will receive assistance
Enrolling in BMS Access Support®

1. Your doctor’s office will need your name, address, insurance carrier, and member identification number.

2. You and your doctor’s office complete the BMS Access Support enrollment form.

3. BMS Access Support conducts a benefits review, which will typically determine what is covered by your insurance plan.

For more information or to apply for assistance, call BMS Access Support at 1-800-861-0048, 8 AM to 8 PM ET, Monday–Friday, or visit www.BMSAccessSupport.com.
**Access:** Your ability to get a particular drug or medical service.\(^{31}\)

**Affordable Care Act (ACA):** The healthcare reform law enacted in March 2010 (sometimes known as the Patient Protection and Affordable Care Act, or “Obamacare”). Under the ACA, people who weren’t covered at work or by public health insurance can now buy health insurance from commercial companies through the Health Insurance Marketplace.\(^4\)

**Allowed amount:** The maximum a healthcare plan will pay for a covered healthcare service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.” If your provider charges more than the plan’s allowed amount, you may have to pay the difference.\(^{16}\)

**Appeal:** A request for your health insurance company or the Health Insurance Marketplace to review a decision that denies a benefit or payment.\(^{16}\)

**Catastrophic health plans:** Health insurance plans that have low monthly premiums and very high deductibles. You pay most routine medical expenses yourself, but you are protected if you get seriously sick or injured.\(^7\)

**Claim:** A request for payment (bill) that you or your healthcare provider submits to your health insurer when you get items or services you think are covered.\(^4\)

**Coinsurance:** A type of cost-sharing after you meet your annual deductible in some health plans. You pay a certain percentage of the cost of a covered service (typically 20%) and your plan pays the remaining amount.\(^{16}\)

**Co-pay/Co-payment:** Another type of cost-sharing in some health plans. You pay a fixed amount ($20, for example) for a covered healthcare service or drug after you’ve paid your deductible. Co-pays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.\(^{16}\)

**Covered charges (eg, drug coverage):** A drug, treatment, or other healthcare service that the insurance company agrees to pay for.\(^{16}\)

**Deductible:** After you pay your insurance premium, the deductible is the amount you pay for healthcare services each year before the health plan starts to pay its share. Each health plan may have a different deductible amount. After you pay your deductible, you usually pay either a co-pay or coinsurance for covered services. Your insurance company pays the rest.\(^{14}\)

**“Donut Hole”:** Term for the gap in payment coverage for drugs after you and Medicare have spent a set amount of money. When you are in this coverage gap, you must pay for a larger share of your drug costs until you have spent a certain amount (yearly limit). After you reach your yearly limit, you will only have to pay 5% of your remaining drug costs until the end of the year.\(^7\)
Employer-based health plan: Coverage that is offered to an employee (and often his or her family) by an employer.4

Formulary: A list of prescription drugs covered by a drug plan or another health plan offering prescription drug benefits (also called a drug list). Drugs may be grouped into “tiers” depending on how expensive they are. More expensive, “higher-tier” drugs may require additional cost-sharing.7

Formulary drugs: Listing of prescription medications which are approved for use and/or coverage by the plan and which will be dispensed through participating pharmacies to covered enrollees.

Healthcare Marketplace (also called Healthcare Exchange): A service that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace, available at HealthCare.gov, for most states. Some states run their own Marketplaces.4

Healthcare plan or health plan: A benefit your employer, union, or other group (such as governmental insurance) provides to you to pay for your healthcare services. Generally plans with lower monthly premiums have higher co-pays. Plans with higher monthly premiums usually have lower co-pays. There are several types of healthcare plans and provider networks, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs).3,4

Health maintenance organization (HMO): A health plan that provides healthcare services to members for a pre-set amount of money. Primary care doctors are often used to determine whether members receive care from specialists.16

Intravenous (IV) infusion: Injection of drugs directly into your veins with a needle. Done by a healthcare professional in a hospital, clinic, or doctor’s office.22

Managed care: Health plans that try to contain costs by contracting with a network of doctors, nurses, hospitals, and other healthcare providers to provide services and drugs at set prices.16

Medicaid: Provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.16

Medicare Part B: The part of regular Medicare that covers medically necessary and preventive services. This includes doctor visits and drugs that are given by doctors at their office.7
Medicare Part C (also called Medicare Advantage): A type of Medicare health plan offered by a private company that contracts with Medicare to provide all of your Part A and Part B benefits, with many of them also providing prescription drug coverage. Medicare Advantage plans include HMO, PPO, and fee-for-service plans, but if you have a Medicare Part C plan, you won’t be covered by original Medicare.7

Medicare Part D: The part of regular Medicare that covers prescription drugs for outpatients (patients not admitted to a hospital).7

Medigap (also called Medicare Supplemental Insurance): Extra health insurance that you buy from a private company to pay healthcare costs not covered by original Medicare, such as co-pays, deductibles, and healthcare if you travel outside the United States.16

Oral drug: A medicine taken by mouth, usually a tablet or capsule (pill) or a liquid.

Out of pocket: A term meaning “to pay out of your own pocket.” Not covered by insurance.4

Plan Document: A document that describes the details of a health plan, what services are covered, what services are not covered, and what charges the patient will be required to pay.

Prescription drug: A drug that doctors must write an order (prescription) for on a piece of paper and provide their license number. A prescription can also be transmitted electronically.

Preferred Provider Organization (PPO): A type of health plan where you pay less if you use doctors, hospitals, and providers outside of the network without a referral for an additional cost.4

Premium: The amount you pay for your health insurance every month.2

Private health insurance (also called commercial insurance): Insurance provided by commercial insurance companies, either to individual customers or as plans offered by employers or unions.16

Public health insurance: Government-run programs, such as TRICARE for active military and their families, the Veterans Health Administration for retired military, the Indian Health Service, and Medicare and Medicaid, offered by Centers for Medicare & Medicaid Services (CMS).3

Subcutaneous (SC) injection: Injection of a drug under your skin with a small needle. Can be done either by a healthcare professional in an office or by yourself at home, if you are taught how to do it by a healthcare professional.24

TRICARE: A healthcare program for active duty and retired uniformed services members and their families.10
References

14. Coverage to Care: A road map to better care and a healthier you. CMS product 11839. Downloaded on October 29, 2018.
If you have questions or are not sure what programs are available to you, please contact BMS Access Support® for a person-to-person conversation about your insurance coverage and your options.

Call 1-800-861-0048, 8 AM to 8 PM ET, Monday–Friday, and speak with a Care Coordinator

Visit www.BMSAccessSupport.com to schedule a call from a Care Coordinator, or to find educational resources.