Understanding Health Insurance

Answers to common questions about healthcare and prescription drug coverage

Learning about health insurance can be challenging. Here we've broken down the basics to help you understand this complex topic, especially where it relates to prescription drug coverage.

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What expenses does health insurance cover?

Generally, health insurance pays for medical and pharmacy expenses, based on the specific plan.

Medical includes expenses for physician and hospital services and covers things like doctor visits, drugs given in your doctor's office or other healthcare facility (drugs that must be given by a medical professional), hospital services and supplies, and some home-health services.

Pharmacy includes prescription drugs that you take by mouth and those you inject at home, like insulin.

Health insurance providers charge you a fee, called a **premium**, in return for paying a portion of these expenses.

How do I get health insurance?

Health insurance is offered by private insurance companies and by the government.

Private health insurance, also called "commercial" health insurance, includes any plan you don't get from the government. It is usually available through your job and is the most common type of health insurance.

Public health insurance is run by the government. Medicare, Medicaid, Veterans Health Administration, and TRICARE are the largest government health insurance programs.

Your age is a clue to the type of health insurance you'll get

If you are under 65 and employed, you probably will get your coverage from a private health insurance company. If you are 65 or older, any age with certain disabilities and health conditions, are low-income, or in the military, public health insurance may apply.

Learn more about health insurance at Medicalnewstoday.com/articles/323367.

What kinds of private health insurance are available and how do I qualify?

About half of all Americans are on private insurance plans.* Most often you qualify for private health insurance through your work, or your parent's or spouse's work. The employer will offer plans that are available in your state. Major health insurers include Blue Cross Blue Shield, Aetna, UnitedHealthcare, and Cigna. You can also buy insurance directly from these companies or through an insurance broker.

If these are not options for you—you are unemployed, self-employed, or a small business owner, for example—certain organizations offer group health coverage for their members. Examples include chambers of commerce and associations for freelance workers. To get coverage, you must be a member of the organization and be able to pay the premiums. Additionally, you can buy health insurance on a **health insurance exchange**.

See what health insurance exchange plans cover at Healthcare.gov.

Learn about prescription drug coverage under commercial insurance on page 6.

Learn more about words in blue by scrolling to the last page, Words to Know. You can find even more definitions related to health insurance and healthcare at Healthcare.gov/glossary.

*Source: KFF.org. Accessed December 20, 2021 at www.kff.org/statedata.

What kinds of public health insurance are available?

Medicare, Medicaid, Veterans Health Administration, and TRICARE are types of public health insurance.

Medicare

Medicare mainly provides coverage for people who are over the age of 65, blind, or are disabled. About 14% of American citizens are on Medicare.* If you are 65 years or older, you are automatically eligible for Medicare. People at any age with certain disabilities or who have end-stage kidney disease or amyotrophic lateral sclerosis (ALS) are also eligible for Medicare.

It is important to understand that Medicare has four different parts: A, B, C, and D. Your benefits will vary based on which of these you select.

Part A	Part B	Part C	Part D
Hospital insurance	**Medical insurance**	**Medicare Advantage insurance**	**Prescription drug insurance**
BENEFITS			
This is your hospital insurance plan. It covers hospital stays, services while you are in the hospital (for example, tests to diagnose your illness), and some follow-up care after you leave.	This is your doctor and outpatient insurance plan. It covers doctor visits, outpatient care, durable medical equipment (DME), home healthcare, preventive services, and any service deemed medically necessary. *Together, Parts A and B are called "Original Medicare" to distinguish them from the newer Part C coverage.*	Called Medicare Advantage (MA), Part C combines Parts A, B, and D, often with additional benefits such as vision and dental care. It works a lot like commercial health insurance, and in fact MA plans are offered and run by commercial insurance companies selected by Medicare.	This is your stand-alone prescription drug plan that can supplement Original Medicare. It is offered by private insurance companies to everyone enrolled in Part A or Part B. Learn about prescription drug coverage under Medicare on page 6.

Medicaid

Medicaid provides health coverage to millions of Americans (about 20% of all citizens*), including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by your state, according to federal requirements. The program is funded jointly by states and the federal government.

Veterans Health Administration/TRICARE Department of Defense (DoD)

The Veterans Administration and DoD offer health insurance for people who are or have been in the military, including veterans, active-duty service members, National Guard and Reserve members, retirees and their families. Military insurance covers the healthcare needs of about 1% of the population.*

Click below to learn more about eligibility

Medicare
Medicare.gov

Medicaid
Medicaid.gov

VA Healthcare
Va.gov/health-care/eligibility

TRICARE
Tricare.mil/plans/eligibility

*Source: KFF.org. Accessed December 20, 2021 at www.kff.org/statedata.

When can I apply for health insurance?

All private and some public health insurance plans have a yearly enrollment period when you can sign up for, change, or drop your plan. This period is called open enrollment, and it's often held in the fall so that you are covered by the plan starting January 1. Private plans do not let you change your plan after open enrollment unless a qualifying life event happens—like getting married, having a baby, or losing other health insurance. Healthcare exchanges and Medicare have their own rules about open enrollment. Learn more at Healthinsurance.org/open-enrollment.

What healthcare costs does the patient pay?

Healthcare expenses are shared by you and your health insurance provider, whether private or public. This means that the health insurance plans can include costs in addition to your monthly premium, including:

Deductible: A set amount you pay for healthcare services each year before the health plan starts to pay its share.

Copayments (copay): A set amount (for example, $20) you pay for a covered healthcare service or drug. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists. Some plans require you to pay the deductible before the copay starts.

Coinsurance: The percentage some plans require you to pay for services once you reach your deductible. For example, for a visit to your doctor, a plan pays 80% and you pay the remaining 20%.

These expenses are also called out-of-pocket (OOP) costs, and what you pay depends on your plan. Commercial plans limit the amount you have to pay OOP each year. This is called your **OOP maximum**.

Healthcare plans usually have a network of doctors, hospitals, labs, and other facilities that they prefer you go to. These are called network providers, and you may have lower OOP costs if you stay in this network. If you go out of network, your OOP costs can be significantly higher.

You may see the terms PPO and HMO when you look at specific healthcare plans:

- PPO stands for Preferred Provider Organization. This is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You can go to any doctor or healthcare facility you want, but you will pay less if you go to the ones that are in the plan's network
- HMO stands for Health Maintenance Organization. HMOs restrict patients to the providers in their network. They will not pay any of the costs if you go out of the network

Your **Summary of Benefits and Coverage** (or Plan Document) will tell you exactly what you need to pay: your premium, what your annual deductible is, copays, and your annual OOP maximum, if there is one.

How are prescription drugs covered by healthcare insurance plans?

You might not think about it, but the way a medicine is given can affect its coverage. Medicines you take yourself are covered differently from medicines that have to be given by a medical professional.

Coverage by how drug is taken

BY MOUTH (ORALLY)

- Pills and liquid medicines are usually taken at home
- Usually covered by your prescription drug benefits

BY INTRAVENOUS (IV) INFUSION

- Drugs that are infused into your veins are usually given at a hospital, clinic, or doctor's office
- Usually covered by your medical benefits

BY SUBCUTANEOUS INJECTION

- Injections given under the skin can be injected at home, in a doctor's office, or in another healthcare facility
- If given at home, they are generally covered by prescription drug benefits; an injection given by a healthcare professional will be covered as a medical benefit

How do I get the medicines my doctor prescribes?

There are several ways to get your medications:

- You can pick up your medications at **retail pharmacies** like CVS and Walgreens that fill 30-day supplies of drugs you take at home
- Your healthcare plan may have a **mail-order pharmacy** where you can get 90-day supplies of drugs you take at home, often for less than what you would pay at the retail pharmacy
- **Specialty pharmacies** handle specialty drugs. Usually specialty drugs are expensive drugs you take at home that treat rare and complex conditions, such as HIV, cancer, autoimmune diseases, and organ transplants. They often require special handling, such as refrigeration. Specialty pharmacies also offer additional support that's often needed with special medications, like financial assistance and education
- Medications given at your **doctor's office** or other healthcare facility are usually provided and billed by the facility

If you need help paying for your Daiichi Sankyo medication, visit us at DSIAccessCentral.com to see if you are eligible for support.

How does private insurance manage prescription drug coverage?

If a prescription drug is part of your **pharmacy benefit** (you take or inject it at home), you will usually pay a set copay or coinsurance based on what tier of your insurance company's formulary the drug belongs to. Many formularies have 3 drug tiers:

Tier 1	Tier 2	Tier 3
GENERIC DRUGS are favored by insurance companies because they are as safe and effective as their brand-name counterparts, but usually cost a lot less	**PREFERRED BRAND-NAME DRUGS** cost more than generics but less than non-preferred brand name drugs	**NON-PREFERRED BRAND-NAME DRUGS** cost you the most out of pocket

Drug companies commonly offer copay cards to people with commercial insurance to help with the cost of brand-name drugs. Visit Access Central to learn about copay cards for Daiichi Sankyo medications.

If a prescription drug is part of your private insurance **medical benefit** (given by your doctor or another provider in a healthcare facility), you will owe a copay or coinsurance. Your cost depends on your plan. While it's common for the doctor's office to let you know the cost before your treatment, be sure to ask just in case your doctor's office doesn't.

How does Medicare manage prescription drug coverage?

Medicare prescription drug coverage is complex, and what follows is a high-level overview.

Original Medicare

A — Part A drug costs are generally covered as part of the hospital stay.

B — Part B covers most drugs that must be given by a professional. You are responsible for a 20% coinsurance after your deductible has been met.* Although there is no OOP maximum for Medicare Part B, private insurance companies offer Medigap coverage to help cover copays and coinsurance. Learn more at Medicare.gov.

Medicare Part D

D — Remember that Medicare Part A and Part B don't cover medications you take on your own. You will have to enroll in Part D to get coverage for them. Part D prescription drug coverage is offered to everyone who has Medicare, but you pay an additional premium. With Part D, the amount you pay for prescription drugs changes throughout the year. You can learn more about this at Medicare.gov.

You may have heard the term "donut hole" in relation to Medicare Part D. People on Medicare enter the donut hole when their total drug costs (what the patient has paid plus what Medicare has paid) reach a certain limit. The limit changes every year. When a patient is in the donut hole, Medigap coverage can help pay for needed medicines.

Medicare Advantage

C — Medicare Advantage (sometimes called Part C) plans provide prescribed drugs at no cost to you after you meet an in-network OOP maximum. Find out how Medicare Advantage plans work at Medicare.gov.

*Source: Medicare.gov. Accessed December 20, 2021.

What if I can't afford my prescriptions under Medicare?

You may be eligible for Low-income Subsidy (LIS) or "Extra Help." The Extra Help program assists people with Medicare prescription drug plans who meet certain income and resource limits. It can help with the premiums, deductibles, and other OOP costs for prescription drugs. Medicare beneficiaries qualify automatically if they:

- Get help for Part B costs from a **Medicare Savings Program**
- Get Supplemental Security Income (SSI) benefits

If you do not qualify automatically, you may need to apply.

Extra Help is a government program run by the Social Security Administration. There's more information at the Social Security website, Ssa.gov, or call 1-800-772-1213. Eligibility requirements apply.

At Daiichi Sankyo, Inc., those in need of treatment are always our top priority. We are committed to helping you get your medications by providing a wide array of patient support to help with access to our treatments. For more information, please visit us at DSIAccessCentral.com.

Words to Know

Coinsurance: The percentage some plans require you to pay for services once you reach your deductible. For example, for a visit to your doctor, a plan might pay 80% and the insured person pays 20%.

Copay: A set amount (for example, $20) you pay for a covered healthcare service or drug. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists. Some plans require you to pay the deductible before the copay starts.

Deductible: The amount you pay for healthcare services each year before the health plan starts to pay its share. After you reach your deductible, you usually pay either a copay or coinsurance for covered services. Your insurance provider pays the rest. This can differ based on your plan. For example, some plans let you visit your primary care doctor without first having to reach the deductible. And you never have to pay the deductible before going for preventive care like an annual physical, because preventive care is paid 100% by your health insurance provider.

Formulary: The list of prescription drugs that are approved for use and covered by your health insurance plan.

Health insurance exchange: An online marketplace where consumers can compare and buy individual health insurance plans.

Insurance broker: An insurance broker makes money off commissions from selling insurance to individuals or businesses. They commonly sell many kinds of insurance, not just for healthcare.

Medicare Savings Programs: These programs may help pay your Medicare costs if you have limited income and savings. They are also known as Medicare Buy-in Programs or Medicare Premium Payment Programs.

Medigap: Extra health insurance that you buy from a private company to pay healthcare costs not covered by Original Medicare, such as copays, deductibles, and healthcare if you travel outside the U.S.

Network providers: Healthcare providers that have contracted with your insurance company to accept certain discounted rates—they charge less for covered services. You will typically pay less with a network provider.

Out of network: Out-of-network providers have not agreed to the discounted rates, so your share of the cost will be more when you go to them.

Out-of-pocket maximum: Insurance plans limit the amount of OOP costs you have to pay during the plan year. After you reach the maximum, your health plan pays 100% of the costs of covered benefits.

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

Summary of Benefits and Coverage (SBC): A snapshot of your plan, including what services are covered, what services are not covered, and what charges you will be required to pay.

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