Your guide to **understanding your medication coverage in 2024**

Commonly used terms and frequently asked questions

Takeda | ONCOLOGY

Understanding **common terms**

This brochure is intended for general informational purposes. Depending on your coverage, always refer to official sources or your healthcare plan for specific information regarding coverage.

A

Appeal

A request you make to your insurance company to reverse a decision you disagree with when denied healthcare services, coverage for a medicine, or payment for services you already received, or if you disagree with a decision to stop services that you are receiving.

B

Benefits

Payment for services provided by an insurance policy. In a health plan, benefits are the healthcare you get.

Benefits investigation (BI)

Sometimes called a benefits verification (BV), a BI is done on your behalf to see if your insurance covers a specific medicine.

C

Case manager

A person who arranges all services that are needed to give proper healthcare to a patient or group of patients.

Catastrophic coverage

If you have Medicare prescription drug coverage, once your spending on prescription drugs reaches a certain amount called the "out-of-pocket threshold," you automatically enter the catastrophic phase of coverage. In 2024, patients reaching this phase will have a $0 copay.

Find more information on how catastrophic coverage will work in 2024 on page 17.

Claim

A request for payment that you or your doctor submits to Medicare or other health insurance when you get items and services that are covered by your health plan.

Coinsurance

An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Co-payment (co-pay)

An amount you may be required to pay as your share of the cost for a medical service or supply, such as a doctor's visit, hospital outpatient visit, or prescription drug. A co-payment is usually a set amount rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Co-pay accumulator

A feature or program within an insurance plan whereby co-pay assistance does not count toward the patient's deductible and out-of-pocket maximum. The manufacturer co-pay program funds prescriptions until the maximum value of the program benefit is reached. After the maximum value is reached, the patient's out-of-pocket costs will again count toward their annual deductible and out-of-pocket maximum.[1]

Co-pay maximizer

A feature or program within an insurance plan that sets out-of-pocket costs equal to the maximum value of the manufacturer's co-pay program benefit. These costs are normally applied evenly throughout the benefit year and payments do not apply toward the patient's annual deductible or out-of-pocket maximums.[1]

Coverage gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap is a phase of Medicare Part D coverage where costs are shared by the plan, enrollee, and drug manufacturer.

See page 17 for more details on how the coverage gap phase will work in 2024.

Coverage gap (cont'd)

If you are on Medicare and get "Extra Help" (a low-income subsidy) to pay Part D costs, you will not enter the coverage gap. For other Medicare Part D enrollees, the coverage gap can begin after you and your drug plan have spent a certain amount for covered drugs.

Covered benefit

A health service or item that is included in your health plan and paid after co-pay/coinsurance/deductible are met.

D

Deductible

The amount you must pay for healthcare or prescriptions before your health plan begins to pay.

Dual-eligible

Someone enrolled in Medicare who also receives the full range of Medicaid benefits offered in their state.

E

Explanation of benefits

A letter or electronic document sent to you by your health plan after a healthcare service, such as a doctor's visit. It is important to know that this is not a bill but simply information about how your health plan processed your doctor's claim. The letter has the following information:

- The name of the doctor you visited
- What kind of healthcare service(s) you received
- How much the doctor charged and how much is allowed by your health plan
- How much money your health plan paid
- How much money was counted toward your deductible amount
- How much money you may be asked to pay by your doctor

F

Formulary

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

H

Health coverage

Legal entitlement to payment or reimbursement for your healthcare costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program, such as Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

L

Low-income subsidy (LIS)

Also called "Extra Help," LIS is a program that helps eligible people with Medicare who have limited income and resources to pay for prescription drug coverage. In 2024, eligibility for full LIS benefits will be expanded to beneficiaries who earn up to 150% of the federal poverty level. If you qualify for Extra Help, you may pay less in premiums, deductibles, and co-payments. Learn more at **www.medicare.gov/basics/costs/help/drug-costs**.

M

Medicaid

A joint federal and state program that helps low-income individuals or families pay for the costs associated with long-term medical and custodial care, if they qualify. Although largely funded by the federal government, Medicaid is managed differently by each state, and programs may be different.

Medicare

The federal health insurance program for people who are 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Part A

Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home healthcare.

Medicare Part B

Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.

Medicare Part C (Medicare Advantage)

Medicare Part C, also known as Medicare Advantage, is a type of Medicare health plan offered by insurance companies to provide you with all of your Part A and Part B benefits. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered by the plan and aren't paid for by Original Medicare (Part A and Part B). Most Medicare Advantage Plans offer prescription drug coverage and all Medicare rules apply. You must be enrolled in Medicare Parts A & B to enroll in a Medicare Advantage plan.

Medicare Part D

Also known as Medicare prescription drug coverage, Part D is a type of Medicare health plan offered by insurance companies to provide you with optional benefits for prescription drugs available to all people with Medicare for an additional cost. Most Part D plans charge a monthly premium that varies by plan. This premium is in addition to the Medicare Part B premium.

Medigap policy

A Medigap policy, also known as Medicare Supplement Insurance, is sold by private companies, which can help pay some of the healthcare costs that Original Medicare doesn't cover, such as co-payments, coinsurance, and deductibles. You must have Medicare A and B to purchase a Medigap policy.

If you have Original Medicare and you buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered healthcare costs. After that, your Medigap policy pays its share.

N

Non-formulary drugs

Drugs not on a list that has been approved by a healthcare plan.

O

Original Medicare

The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). This is a pay-per-visit health plan that lets you go to any doctor, hospital, or other healthcare supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance).

Out-of-pocket (OOP) costs

Healthcare costs that you must pay on your own because they are not covered by Medicare or other insurance.

P

Pharmacy benefit / Prescription drug coverage

The pharmacy benefit is part of your health insurance that tells how much coverage you will receive and what types of prescription drug coverage are available to you. Prescription drug coverage is a plan that helps pay for prescription drugs and medications.

Pharmacy benefit manager (PBM)

Organizations that manage pharmaceutical benefits for managed care organizations, other medical providers, or employers. PBM activities may include some or all of the following: benefit plan design, creation/administration of retail and mail service networks, claims processing, and managed prescription drug care services such as drug utilization review, formulary management, generic dispensing, prior authorization, and disease and health management.

Premium

The periodic payment (usually monthly) to Medicare, an insurance company, or a healthcare plan for health or prescription drug coverage.

Prior authorization

Approval you must get from your health plan before you receive a healthcare service or fill a prescription in order for that service or prescription to be covered by your plan.

R

Retail pharmacy

A local pharmacy (such as Safeway, Costco, Rite Aid, etc) that includes the retail sale of prescription medicines and other over-the-counter medicines.

S

Specialty drugs

Medicines prescribed for people with complicated or high-cost medical conditions. These medicines are often injected or infused but may also be taken by mouth. They may have unique storage or shipment requirements.

Specialty pharmacy

A pharmacy that handles specialty drugs and other services for patients with rare and/or chronic diseases. Specialty drugs are often delivered directly to a patient's home.

Step therapy

A coverage rule used by some health insurance companies that requires you to try one or more similar, lower-cost drugs to treat your condition before the plan will cover the prescribed drug. Your doctor will need to consent and prescribe the lower-cost drug.

T

True out-of-pocket (TrOOP) costs

The amount you pay for covered Part D drugs that count toward your drug plan's out-of-pocket threshold that must be reached before your catastrophic coverage can begin. Your yearly deductible, coinsurance or co-payments, and what you pay in the coverage gap all count for this out-of-pocket limit. This amount also includes payments made on the enrollee's behalf, such as manufacturer payments made in the coverage gap.

Frequently asked questions:

A guide to your medication coverage and help that may be available.

How can I find out if my insurance company will cover my medicine?

Your doctor's office or pharmacy will often contact your insurance company to see if you have coverage for a certain medicine. You may also contact your insurance company directly to review your benefits information and see if a certain medicine is covered.

Some drug manufacturers have patient programs that will help you understand your coverage, including financial assistance options. Ask your doctor if there is a program for the medicine you are being prescribed that can help with payment. If you have access to the Internet, you can also search online for your medicine to see what services are offered on the medication's website.

What happens when my medicine comes from a specialty pharmacy?

Unlike a local **retail pharmacy** that fills most medicines, **specialty pharmacies** usually handle the delivery of medicines for complicated diseases that require extra attention. The specialty pharmacy may also offer more support and services than a local retail pharmacy. These services can help you access your medicine and manage your condition by:

- Offering support from a pharmacist
- Helping to find out if your insurance pays for your medicine
- Educating you about your disease and the medicine you are taking
- Following up with your doctor
- Helping stay on schedule with your medicine
- Providing information about financial assistance

Please contact your specialty pharmacy to find out if their calls will appear as an unknown caller on your phone.

I do not have insurance. Is there assistance available to help pay for my treatment costs?

We understand you may need help paying for your medicine. Consult your doctor, insurance plan, or manufacturer's website to find out about available assistance programs that can help eligible patients who may not be able to afford the cost of their medicine.

My insurance company is taking a long time to tell me if it will pay for my medicine. What can I do?

Many drug companies have patient programs that may help you get started on your medicine before your insurance company approves your prescription. Ask your doctor if there are any programs available for the medicine you are prescribed.

Terms in bold can be found in the glossary section.

How do I know if my plan has a co-pay accumulator or co-pay maximizer that may affect my coverage?

Please reach out to your insurance provider directly to learn if your plan has a co-pay accumulator or co-pay maximizer that may affect your coverage.

What is a co-pay assistance program?

A co-pay assistance program offers financial help for your medicine-related **co-payments**. Many drug companies offer a co-pay assistance program. Some programs use a physical card that may be mailed to you and some may use electronic cards only. These programs are sometimes also known as co-pay card programs.

Co-pay assistance programs are only open to eligible patients with private insurance.

Terms in bold can be found in the glossary section.

My insurance plan has a co-pay accumulator. When will I have to start paying out-of-pocket for my medication?

Your co-pay card will fund prescriptions until the maximum value on the card is reached. Check with your insurance provider to confirm your co-pay card's maximum value. Once the maximum value is reached, you can expect to start paying out-of-pocket. These payments will begin counting toward your annual deductible and out-of-pocket maximum.

Is there any financial assistance available to help me pay for my monthly co-pay or coinsurance?

We understand that you may need help with **out-of-pocket costs** for your medicine. Many drug companies offer co-pay assistance programs for eligible patients covered by private insurance companies. These programs may help you pay for your medicine.

Be sure to talk to your doctor first about what patient assistance programs may be available for your medicine.

How does my co-pay accumulator affect my out of pocket costs in 2024*?

Coverage begins January 1

Medication cost

$2,000

Accumulation begins:

Manufacturer co-pay card dollars do not count toward deductible and OOP maximum

$2,000 medication cost
- $1,995 manufacturer co-pay card

Member cost share:

$5.00

Applied to deductible:

$5.00 applied to member's deductible

Dollars applied to OOP maximum†:

$5.00 applied to member's OOP maximum

Where co-pay accumulator programs are not in effect, the full $2,000 would be applied to meet the member's deductible and OOP maximum.

*Dollar amounts provided as an example.

†OOP maximum is the most you could pay for covered medical services and/or prescriptions each year.

‡The calendar year is defined as January 1 to December 31.

Terms in bold can be found in the glossary section.

How does Medicare coverage work in 2024?

Coverage begins January 1‡

Deductible[2]

Enrollee pays 100% of drug cost: up to $545 in 2024

Initial plan coverage begins[2,3]:

Enrollee pays coinsurance for prescription drugs

Enrollee pays 25% coinsurance; plan pays 75% until total drug costs reach $5,030

COVERAGE GAP/"DONUT HOLE"[2,3]

Enrollee pays 25% coinsurance while in the coverage gap until true out-of-pocket (TrOOP) spending reaches $8,000.

Generic drugs:	Brand-name drugs:
Enrollee pays 25%	Enrollee pays 25%
Plan pays 75%	Plan pays 5%
	Manufacturer discount payment: 70%

Catastrophic coverage begins[3]:

In 2024, the catastrophic threshold is set at $8,000, which includes payments to be made by the patient and payments to be made on the patient's behalf. Enrollees who take only brand-name drugs will pay around $3,300 out of pocket before reaching the catastrophic phase (this estimate is based on using brand drugs only). Patients who reach this phase of coverage will have a $0 co-pay.

Catastrophic coverage continues until the end of the year[4]

Coverage ends December 31

Notes

Use this section to write down any notes or questions you may have for your doctor and/or health plan about your prescription drug coverage.

References: 1. Copay accumulators and copay maximizers. American Society of Clinical Oncology (ASCO). Accessed July 28, 2023. https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2021-AccumulatorsPolicyBrief.pdf **2.** Announcement of calendar year (CY) 2024 Medicare Advantage (MA) capitation rates and Part C and Part D payment policies. CMS.gov. March 31, 2023. Accessed July 28, 2023. https://www.cms.gov/files/document/2024-announcement-pdf.pdf **3.** Changes to Medicare Part D in 2024 and 2025 under the Inflation Reduction Act and how enrollees will benefit. Kaiser Family Foundation. Accessed July 28, 2023. https://www.kff.org/medicare/issue-brief/changes-to-medicare-part-d-in-2024-and-2025-under-the-inflation-reduction-act-and-how-enrollees-will-benefit/# **4.** Catastrophic coverage. Accessed July 28, 2023. https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/catastrophic-coverage

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