Managing the Maze of Insurance
Practical Insights for Patients with Cancer
Practical Steps for Patients Living With Cancer

Health care insurance is very important for anyone with a serious illness such as cancer. Whatever your current health coverage, you should take practical steps to understand your plan and get the coverage you need. This patient guide offers information on how you can do that.

Using this Guide

This guide will help you

- Understand the basics of health insurance (page 3)
- Find resources to help you manage your finances (page 10)
- Figure out how to get and pay for the medicine you need (page 11)
- Get answers to common questions (page 15)
# Table of Contents

Understanding Health Insurance Plans ................................................................. 3
Managing Your Finances .......................................................................................... 10
Prescription Drug Coverage: How to Get the Medicine You Need ......................... 11
Common Questions and Things to Remember ....................................................... 15
Key Steps to Your Health Care Coverage ............................................................. 18
Frequently Asked Questions (FAQs) ...................................................................... 19
Helpful Resources .................................................................................................... 20
Glossary .................................................................................................................... 21
Notes ......................................................................................................................... 23
My Important Contacts and Health Insurance Information ..................................... 24
Understanding Health Insurance Plans

Health Insurance is an Agreement

Health insurance is an agreement between you and your insurer. In this agreement, you pay a fee to the insurer, commonly known as the “monthly premium” or fee. In return, the insurer agrees to help pay for your medical bills and/or prescription medication expenses when you need care.

Health Insurance May Help Pay for Different Kinds of Care:

- Clinic visits
- Hospitalization
- Tests
- Medications

Learn more about the kind of insurance policy you have to understand what is covered.

Basic Terms: Know Your Health Insurance Coverage

It is important to understand your insurance coverage. Insurance plans can change, and it’s a good idea to review your coverage from time to time. Here are some important terms you need to understand:

- **Premium:** The cost of the plan. This is usually paid each month.
- **Deductible:** The amount of medical and pharmacy expenses you need to pay each year before the insurance benefits begin.
- **Copayments:** A fixed dollar amount you pay at the time of medical service. You pay this amount when you visit the clinic, have tests done, or you pick up a prescription medicine.
- **Coinsurance:** The percentage of expenses you share with your health plan. For example, you may pay 20% and the plan pays 80%.

- **In-network and out-of-network:** Some health insurance plans have a network or participating health care providers. The cost of using a health care provider who is in your plan’s network is usually much less than the cost of using a provider who is not in your plan’s network. Some insurance plans only provide in-network benefits so providers need to make sure they are aware or benefits may not be payable for services provided. See the box on this page for more information about networks.

- **Lifetime and annual maximums or “caps”:** The total amount of money a plan will pay while you are enrolled in the plan during your lifetime and during each year. You will have to pay for the cost of care that is more than this “cap.” Under the Affordable Care Act, plans that began on or after September 23, 2010, can no longer impose lifetime caps. Plans that began on or after January 1, 2014, cannot impose annual limits on essential health benefits.

What is a health care network?

A health care network is a list of doctors and health care providers plus hospitals, clinics, and pharmacies who have a contract to provide medical care to members of the network. Health care providers and others who do not have a contract with the plan are called “out-of-network.”
Private Plans and Government Programs

There are two main categories of health insurance: private health insurance and government programs. Table 1 shows who can get these kinds of insurance plans.

Private health insurance plans are offered by privately owned insurance companies. You can purchase private plans through an employer, directly from an insurance company, or through a state or federal health care exchange.

What is a health insurance exchange?

A health insurance exchange is a marketplace where consumers can purchase insurance. Under the Affordable Care Act, there are exchanges for individuals and small employers to purchase insurance. Each state can choose whether to operate its own exchanges. Consumers in states that do not have their own exchange can purchase coverage through a federally run exchange.

Government Programs include Medicare and Medicaid.

Medicare is public health insurance for Americans aged 65 and older and for some people with certain kinds of disabilities. Medicaid is another kind of public health insurance for low-income families who cannot afford private insurance.

<table>
<thead>
<tr>
<th>Table 1. Who is eligible?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Private Insurance Plans</strong></td>
</tr>
<tr>
<td>Through Employer</td>
</tr>
<tr>
<td>Through Health Care Marketplace Exchanges</td>
</tr>
<tr>
<td>Bought Individually</td>
</tr>
<tr>
<td><strong>Government Programs</strong></td>
</tr>
<tr>
<td>Medicaid</td>
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Private Insurance

Most Americans under the age of 65 are covered by some form of private insurance (Table 2).

<table>
<thead>
<tr>
<th>Table 2. Kinds of Private Insurance</th>
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<tr>
<td><strong>Fee for Service (FFS)</strong></td>
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<tr>
<td>- You choose your health care provider.</td>
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<tr>
<td>- The insurance company either pays the health care provider or reimburses you for your medical expenses.</td>
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<tr>
<td>- This type of insurance plan may be more expensive than other kinds of plans.</td>
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<tr>
<td><strong>High-Deductible Health Plan (HDHP)</strong></td>
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<tr>
<td>- Plans with higher deductibles and lower monthly premiums</td>
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<tr>
<td>- You pay more health care costs before the plan starts paying costs</td>
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<tr>
<td>- In 2018 and 2019, these are defined as any plan with a deductible of at least $1,350 for individuals or $2,700 for families</td>
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<tr>
<td>- You may have a Health Savings Account (HSA) that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. The contribution limit for 2018 is $3,450 for an individual and $6,900 for a family. In 2019, the contribution limit is $3,500 for an individual and $7,000 for a family.</td>
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<tr>
<td><strong>Preferred Provider Organization (PPO)</strong></td>
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<td>- Similar to an FFS plan, in a PPO you can choose your health care provider. But you pay less if you choose a health care provider who is in the insurance company’s network.</td>
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<td><strong>Health Maintenance Organization (HMO)</strong></td>
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<td>- Provides care through a network of health care providers in a certain area.</td>
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<td>- Usually requires that you choose a primary care doctor who you see first when you get sick. If necessary the primary care doctor will refer you to a specialist.</td>
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<tr>
<td>- This kind of plan may cost less than others, as long as you use health care providers and pharmacies in the network.</td>
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<tr>
<td>- If you use a health care provider or pharmacy outside the network, you may pay more for your care.</td>
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<tr>
<td><strong>Point of Service (POS)</strong></td>
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<tr>
<td>- This kind of plan is like an HMO, but it lets you use health care provider outside of the insurance plan network.</td>
</tr>
<tr>
<td>- If you use health care providers outside of the network, you pay more.</td>
</tr>
<tr>
<td><strong>Exclusive Provider Organization (EPO)</strong></td>
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<tr>
<td>- This kind of plan is also like an HMO, but you may not have to have a primary care physician.</td>
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<tr>
<td>- There is no coverage for health care providers who are outside the network.</td>
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Understanding the Affordable Care Act

The Affordable Care Act (also known as the ACA) was passed in 2010. It has led to many changes in how Americans get and use health insurance. The law was intended to protect consumers and make sure that virtually all Americans had affordable health insurance.

Some of the major features include:

- A “Patient’s Bill of Rights” that says people can no longer be denied insurance due to a pre-existing condition. It also ends lifetime limits on coverage, and guarantees that a patient can appeal when an insurance company doesn’t pay medical bills.
- The “Health Insurance Marketplace” with insurance for people who can’t get insurance through their employers.
- Tax credits for families that can’t afford the full cost of plans on the Marketplace.
- Free preventive health care (through in-network providers).
- Lower cost of prescription drugs for seniors on Medicare (making “the donut hole” smaller).

Other Kinds of Private Insurance and Health Exchange Plans

**Catastrophic Coverage** plans pay for hospital and medical expenses of a catastrophic illness. They typically have lower premiums, but higher deductibles, than other plans. This kind of coverage usually does not cover regular doctor visits.

**Disability Insurance** pays benefits if you suffer an injury or illness that prevents you from working. Monthly benefits depend on the details of the plan. There may be restrictions on when this plan becomes effective and how long you are eligible for benefits.

**Hospitalization Insurance** covers hospital and physician charges related to a hospital stay. These plans may pay for the hospital room, surgery, diagnostic tests, and other hospital services. Some plans may also pay for a stay in an extended facility. There may be limits on how much the plan will pay, but there usually is no deductible.

**Long-term Care Insurance** includes a number of services for people who have health- or age-related disabilities. Most long-term care is not medical care, but assistance with “Activities of Daily Living (ADL).” Activities of Daily Living include what you do every day, like bathing or dressing.

When You Don’t Have Private Insurance

Your health care office or clinic may be able to help you find other insurance coverage. Ask a nurse or social worker if you may be eligible for benefits under a public program funded by the government. These programs pay for health insurance, disability benefits, or make cash payments to qualified patients.

Ask if you may qualify for

- Medicare
- Medicaid
- Veterans benefits
- Social Security Disability Income (SSDI)
- Supplemental Security Income (SSI)
Navigating Medicare

What is Medicare?
Medicare is government health insurance for people aged 65 and older. Some people younger than 65 with certain disabilities can also get Medicare. Medicare has four parts (A, B, C, and D) with different benefits, costs, and eligibility requirements.

Who can get Medicare?

**Medicare Hospital Insurance (Part A)**
- All citizens and permanent residents of the United States who are 65 or older are eligible.
- Generally, a person is eligible to receive Medicare Hospital Insurance if they or their spouse are eligible to receive Social Security or railroad retirement benefits.
- People and their spouses who have worked in a government job and paid Medicare taxes may also be eligible if they have held the job for a long enough time.

**Medicare Medical Insurance (Part B)**
- People who are eligible for Medicare Part A can purchase Medicare medical insurance (Part B) by paying a monthly premium.

**Medicare Advantage Plan (Part C)**
- People who are eligible for Parts A and/or B have the option of purchasing a Medicare Advantage Plan (Part C).
- These plans are offered by private insurance companies approved by Medicare. They provide extra health coverage and may lower your out-of-pocket costs.
- They include managed care plans, preferred provider organizations, fee-for-service plans, and specialty plans.

**Medicare prescription drug coverage (Part D)**
- If you are eligible for the other parts of Medicare, you also have the option of purchasing Medicare prescription drug coverage (Part D).

The Parts of Medicare

Traditional Medicare (Parts A, B, and D) and Medicare Advantage Plans (Part C)
Medicare Parts A and B are referred to as **Original Medicare**. Parts A and B are provided by the government. People who are eligible for Original Medicare may choose to buy a **Medicare Advantage Plan** (Medicare Part C) in addition. Medicare Part C is private insurance that is approved by Medicare. Medicare Part C plans often provide extra coverage and may reduce out-of-pocket costs (the cost you pay for your care). Table 3 summarizes what’s covered in the different Parts of Medicare.
Five Things to Know About Medicare Advantage Plans (Medicare Part C)

1. People in Medicare Part C are still in the Medicare program and have the rights and protections of Original Medicare. They still get complete Part A and B coverage through the plan.

2. You can get a Medicare Advantage Plan even if you have a pre-existing condition (except for end-stage renal disease).

3. If you are in a Medicare Part C HMO or PPO plan, you may pay more if your care provider is not in the plan’s network.

4. Medicare Advantage plans cannot charge more than Original Medicare for care like chemotherapy, dialysis, or skilled nursing care.

5. Some costs of participating in a clinical research study may be covered under the plan. Contact your plan for more information.

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Table 3. The Parts of Medicare and What’s Covered

| Part A (Hospital Insurance) | • Care in a hospital  
|                           | • Care in a skilled nursing facility  
|                           | • Hospice care  
|                           | • Home health care |

| Part B (Medical Insurance) | • Doctor and clinic visits  
|                           | • Visits to other health care providers  
|                           | • Home health care  
|                           | • Durable medical equipment  
|                           | • Some preventative services |

| Part C (Medicare Advantage) | • Includes all benefits under Parts A and B  
|                           | • Usually includes drug coverage (Part D) as part of the plan  
|                           | • Run by private insurance companies approved by Medicare  
|                           | • May include more benefits for an extra cost |

| Part D (Medicare Prescription Drug Coverage) | • Helps cover the cost of prescription drugs  
|                                           | • Run by private insurance companies approved by Medicare  
|                                           | • Can lower prescription drug costs and project against higher costs in the future |
Medicare: What are my options?

Follow this chart to help make a decision on which kind of Medicare is right for you

**Step 1: Deciding between Original Medicare or a Medicare Advantage Plan**

**Original Medicare (Parts A & B)**
- Includes Part A (Hospital Insurance) and/or Part B (Medical Insurance)
- You can choose any doctor or hospital that accepts Medicare
- Usually you must pay deductibles andcoinsurance unless you have supplemental coverage
- Most people pay a monthly premium for Part B (Medical Insurance)

**Medicare Advantage (Also called Part C)**
- Includes both Part A and Part B
- Provided by private insurance companies approved by Medicare
- You must use the plan’s doctors or you will pay more or all of the costs
- You may pay a monthly premium in addition to your Part B premium
- You may have to pay deductible, copayments or coinsurance
- Costs and extra coverage vary by plan

**Step 2: Decide if you want prescription drug coverage (Part D)**

**Step 2: Decide if you want prescription drug coverage (Part D)**
- To get prescription drug coverage, you must join a Medicare Prescription Drug Plan
- Plans are run by private companies approved by Medicare
- You will usually pay a monthly premium for your drug plan

**Step 3: Consider Supplemental Coverage**

**No Supplemental Coverage is Offered for Medicare Part D**
- You cannot buy Medigap policy if you have a Medicare Advantage plan unless you leave your plan and join Original Medicare

With Traditional Medicare, you have the option to buy Medicare Supplement Insurance (Medigap)
- These policies are offered from private companies
- Costs vary
- You may be able to get similar coverage through your employer or union
Managing Your Finances

What are your financial challenges?

Paying for health care, along with normal life expenses, is a concern for many people living with cancer. Treatment for cancer can create some financial hardships for you and your family. Some challenges may include:

- Less household income because you need to work less or stop working
- Expensive or unaffordable treatment
- Treatment or prescription medications that are not fully covered by insurance
- Extra costs from transportation, childcare, lodging, and in-home assistance

Here are some strategies that may help you with the cost of health care.

Request a Case Manager From Your Insurance Company

Your insurance company may have a case manager to help you understand your insurance. Contact your case manager first to get information about your health insurance claims and your policy.

Ask Your Health Care Provider About the Cost of Treatment Up Front

You will worry less when you face financial issues early on. Ask about the cost of the treatment or medicine your health care provider recommends. Knowing the cost early on gives you time to plan for any extra expenses.

Appoint a Financial Advocate

During treatment, you may not have enough time or energy to manage your finances. You may want to consider asking a family member or close friend to help you. This person can be your “financial advocate” to help you stay on top of bills, insurance paperwork, and other financial matters. Knowing you have someone helping with your finances may improve your peace of mind during this stressful time.

Consider Taking a Medical Leave

Depending on your treatment and side effects, you may want to take some time off from work. If you and your employer qualify under the Family and Medical Leave Act (FMLA), you have the right to take an unpaid, job-protected medical leave with continued health insurance coverage. The amount of time you are allowed to take off may vary. Talk to your social worker or your human resources department at work to get more details.
Prescription Drug Coverage: How to Get the Medicine You Need

Private Insurance: Check Your Plan

Figuring out what drugs are covered on a private health plan can be confusing. Things that can affect how much you will pay include:

- Whether or not a drug is covered on the plan
- Which pharmacy fills the prescription
- Amount of copayment required for each medication

Get Help From Your Employer or Plan Sponsor

If the medication or treatment you need is not covered, contact your employee benefits office or your plan sponsor to get help. The employee benefits office may be able to request a change in coverage or a speedy review of your case.

What is a formulary?

Every health plan has its own formulary. A formulary is a list of drugs covered by the plan. You may have to pay a higher cost or the full cost of the drug for medications that are not included in the formulary. In addition, many formularies have different levels of tiers of coverage for different drugs. The higher the tier, the more a drug will cost you. Generic drugs are usually less expensive than brand-name drugs. Sometimes, brand name drugs are labeled “preferred” and others used to treat the same problem are labeled “non-preferred.” Preferred drugs are generally less expensive.

Tier Levels Within a Typical Formulary

- Generic Drugs (Tier 1)
- Brand-Name Drugs (Tier 2/3)
- Novel/Specialty Medications (Tier 4)

If you are denied coverage you can appeal.

If your insurance company denies coverage for your prescription medication, talk to your health care provider. Most clinics have an office manager or billing specialist who can help you. If you are denied coverage, you may be able to appeal. With the help of your health care provider, you may be able to file a revised claim to get your medication covered.
Changes to the Affordable Care Act and How They May Affect You*

1 Ending the “donut” hole**. The Affordable Care Act is gradually ending the Medicare Part D coverage gap. The gap will be completely closed by 2019.

2 Decreased open enrollment period. Consumers previously had three months to sign up on the federal exchange. The enrollment period is now only six weeks.

3 More difficult to sign up for insurance at other times. Those seeking coverage during special enrollment periods because of a job loss, divorce, or other major life changes have to provide documentation proving their eligibility.

Understanding Medicare Drug Coverage

Medicare Parts A and B: what do they cover?

Here’s a summary of what Medicare Parts A and B cover:

- Medications you get while in a hospital or skilled nursing facility are most likely covered by Medicare Part A.
- Medication you get in a doctor’s office or clinic may be covered under Medicare Part B. Some examples of treatments that are covered under Part B include:
  - Certain shots
  - Drugs that are given through an infusion pump or nebulizer
  - Oral cancer drugs
  - Oral anti-nausea drugs

Medicare part B requires you to pay 20% of each drug’s costs after your meet your deductible.

Did you know?

Medicare: Does it cover all cancer medications?

Medicare drug plans are required to cover almost all cancer treatments.

- Coverage may occur under part B or D. Which Part covers the treatment can change out-of-pocket costs.
- Sometimes a drug is not listed in a plan’s formulary. If this happens, contact your doctor for help.

*The Trump administration pursued several major efforts to repeal and replace the Affordable Care Act but were unable to get a bill through the U.S. Senate in 2017. The Trump administration’s actions and decisions revamped the 2018 marketplace open enrollment season and may continue to reshape how Americans get health insurance into 2019 and beyond.

**Most Medicare Drug Plans have a coverage gap, sometimes called the “donut hole,” during which the patient may be responsible for a greater portion of the cost of their prescription drugs covered under Medicare Part D. This means there is a temporary limit on what the drug plan will cover for drugs.
Part C: What is Medicare Advantage?

Medicare Advantage (Part C) is another way to get Medicare coverage. Medicare Advantage plans are offered by private companies approved by Medicare. Plans are typically HMO or PPO plans and often include prescription drug coverage. Medicare Advantage plans include both Hospital Insurance (Part A) and Medical Insurance (Part B). With these plans, people usually get medical services from providers in a network. If you have Medicare Advantage plan prescription drug coverage and you join a Medicare prescription drug plan, you will be taken off of your Medicare Advantage plan and returned to Original Medicare.

Part D: Prescription Drug Benefit Plan

Medicare Prescription Drug Plans (PDPs) add prescription drug coverage to Traditional Medicare. You must have Medicare Part A or Part B to join a Medicare Prescription Drug Plan.

All Medicare Drug Plans have a minimum level of coverage set by Medicare, but exact coverage and cost varies by plan. There may be differences in the prescription drugs plans cover, cost of medications, and which pharmacies you can use.

The Coverage Gap or “Donut Hole”

Most Medicare Drug Plans have a coverage gap, sometimes called the “donut hole.” After you spend a certain amount on covered drugs in a given year ($3,750 in 2018 and $3,820 in 2019), you must pay a percentage of the cost of medications up to total amount in that same year ($5,000 in 2018 and $5,100 in 2019). This is the gap in coverage. After you have spent that amount, you will automatically receive “catastrophic coverage.” At that point, you only pay a coinsurance or copayment amount for the drugs you buy until the end of the year. The donut hole will end when you spend a total of $5,100 out-of-pocket in 2019. Figure 1 shows how the coverage gap works.
How can I lower my costs in the donut hole?

- Join a Part D drug plan that provides benefits for generics during the coverage gap
- Seek assistance from national and community-based charitable programs
- Apply for pharmaceutical manufacturer-sponsored assistance programs
- See if you are eligible for “Extra Help” from Medicare or state programs (Medicaid)

Check the resources on page 20 for more information.

Did you know? Under the Affordable Care Act the coverage gap will be closed by 2019.
Common Questions and Things to Remember

What to do if Coverage is Denied

What do I do if insurance doesn’t cover the cost of my cancer medications?

It’s important to take good notes as you learn new information. Each time you contact medical professionals or an insurance company, keep a record of the staff member you spoke with and the date of the conversation. Ask for copies of claim forms and other documentation. These notes and records will be important if you need to file an appeal.

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<tr>
<th>Steps</th>
<th>What to do</th>
<th>Questions to Ask</th>
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</table>
| Step 1 | Call your doctor’s office and speak with the office manager or billing specialist. | • Could a mistake have been made in my bill?  
• Were treatment guidelines (“approved use”) followed?  
• Was the drug administered correctly (right dosage; right method; right frequency)?  
• Was the doctor or nurse required to play a certain role in the drug administration?  
• Were the health insurance company’s procedures for the use of this drug followed?  

Your answers may lead to a revised claim or further action by your health care provider’s office. |
| Step 2 | Contact your health insurance company, and seek help in understanding what can be done when prescription drug coverage was denied. | • Is it possible that a mistake was made?  
• If not, how do I appeal a denial of coverage?  
• If my appeal is also denied and we have a dispute, how is a dispute resolved?  
• Are there important deadlines that I need to meet?  
• Is there anything else I can do to get coverage for this needed medication or service?  

If something does not make sense, ask for clarification. You may also be asked to submit additional forms or copies of key documents. |
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<th>Steps</th>
<th>What to do</th>
<th>Important Points</th>
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| Step 3 | Ask your physician to prepare a letter of appeal. This appeal letter is known as a “Letter of Medical Necessity.” The letter explains the medical need for the denied treatment, procedure, or prescribed drug, and is sent to the insurance company. | If you are sending this letter to your insurance company, be sure to:  
• Attach a copy of your denied claim and any supporting documents that will help in your appeal  
• Make a copy of the entire correspondence  
• Send via registered mail |
| Step 4 | Seek help from the drug manufacturer. Most drug companies have hotlines, or toll-free phone numbers, that patients can call for help with medical and drug-related questions. | Contact information (either telephone or online) for a drug company is often provided on the product information sheet that came with the medication. |
| Step 5 | Write and send your letter of appeal. | In your letter, remember to include:  
• Your identification. Include your policy number, claims number, group number, and other information necessary to identify your case.  
• The reason for the denial. This should be explained in the denial letter.  
• A history of the illness and its treatment. This information should also be included in your Letter of Medical Necessity.  
• What you are asking the insurance company to do. Usually this means asking the insurer to reconsider the denial and approve coverage quickly. If you believe that there was a mistake, present the correct information as well. |

**Appeals are Common**

You should understand that appeals to insurance companies are common. The need to appeal denial of coverage should not be viewed as an end to therapy selection.

The Department of Labor estimates that one out of every seven insurance claims is denied. While most people who are denied don’t appeal, half of those who do are successful.
How can I get help paying for cancer medications?

Many organizations offer assistance to patients with serious illnesses or to older Americans with limited incomes. Assistance is available to people who are insured, underinsured, or have no health care coverage at all.

**Patient Assistance Programs (PAPs)**

Patient Assistance Programs offer free or discounted prescription medications to people in need. These public service programs are supported by pharmaceutical manufacturers. Support is generally offered to patients without prescription drug coverage who also don’t qualify for state or federal government programs that will pay for medications.

PAPs set their own eligibility requirements. Call the specific manufacturer to get details on how their program works.

**State Pharmaceutical Assistance Programs**

Many states have programs to help people pay their drug plan premiums and other drug costs. For more information, see Helpful Resources on Page 20.

**Getting financial assistance**

You may also be able to get financial aid for expenses related to your treatment. A good first step is partnering with the financial services department at your treatment center. They can help you get the most out of your insurance coverage.

**You may also use these strategies for financial assistance:**

- Work with your health care provider to create a payment schedule you can manage
- Apply for grants or financial aid from employers, labor unions, community service organizations, religious or fraternal groups, or cancer support organizations

**Reminder!**

Things to gather before you apply for assistance:

- Bank account statements
- Investment statements
- Tax returns
- Pension award letters
- Payroll slips

**Questions to Ask Your Health Care Provider**

- What will be the cost of this treatment?
- Is this treatment expensive?
- Is there a similar treatment?
- Do you know if my insurance plan covers this treatment?
- Who can help me find out if I’m covered for this treatment?
- Do you know of any financial assistance programs for this treatment?
- Could I get this kind of treatment at a lower cost if I join a clinical trial?
- Is there any way the cost of this treatment could be adjusted to match my financial situation?
- If I need to pay for treatment, can we work out a monthly payment schedule that would not be a large financial burden to me?
Key Steps to Your Health Care Coverage

Partner With Your Health Care Team to Understand Your Treatment Plan and Health Care Coverage

Your health care team may include physicians, nurses, medical assistants, pharmacists, lab professionals, physical therapists, family members, social workers, and mental health professionals. But don’t forget: you are the most important member of your health care team! You can make a difference in the health care you get. Come to appointments prepared, ask questions, and communicate concerns to your team.

Understanding Your Explanation of Benefits (EOB)

Part of taking control of your health care team means understanding your health care benefits. A good place to start is the Explanation of Benefits (EOB). This is a statement that your insurance provider gives you when a claim is processed. The EOB shows your plan’s payments to your health care providers and the charges you will have to pay. These charges may be sent to you as a separate bill soon after, usually by mail.

The EOB is a list of services provided by a health care provider, facility, or hospital. This list includes important facts, like:

- Service date
- Name of the provider
- Whether the provider was in-network or out-of-network
- Covered expense for the service
- Amount that was paid by your insurer (sometimes called “approved” or “paid provider”)
- Amount to be charged to you (sometimes called “non-covered” or “patient responsibility”)

Medical billing errors do sometimes happen. It is wise to keep all EOB statements and to review them for accuracy.
Frequently Asked Questions (FAQs)

Can I join a Medicare Part D prescription drug plan even if I have cancer?
Yes, Medicare Part D drug plans must accept all eligible applicants living in their service area, regardless of health condition or age. The applicant must be a Medicare beneficiary.

Most of my cancer medications are covered under Medicare Part B. If I sign up for Medicare Part D, will that change?
No. The drugs now covered under Medicare Part B will still be covered under Part B, especially if these drugs are part of your chemotherapy treatment and given to you by the doctor or nurse in the physician’s office. Part D may help with other prescriptions, such as certain oral cancer medications.

I am applying for Medicare health and prescription drug insurance. Should I consider cancelling my prescription drug plan provided by my current or former employer?
No. If you cancel your private drug plan, you may inadvertently terminate health coverage for you and members of your family. This is an important decision requiring assistance from your private health plan or your employer. Additionally, Medicare allows for combined coverage provided by a Medicare plan and private health insurance, which can be beneficial to you.

How can I find out more about the health care exchanges?
You can find additional information about the health care exchanges at www.healthcare.gov.

Who can I call to get help?
Medicare’s main number: 1-800-MEDICARE (1-800-633-4227)
If you would like someone call Medicare for you, you will need to fill out a “Medicare Authorization to Disclose Personal Health Information” form and mail it to:
Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

For Health Insurance Exchange questions, you can contact Healthcare.gov at: 1-800-318-2596
The Leukemia & Lymphoma Society (LLS)
Provides information, support and advocacy for people with blood cancer.
www.LLS.org

National Organization for Rare Disorders (NORD)
A resource for the 30 million people in the United States fighting rare diseases.
www.RareDiseases.org

Partnership for Prescription Assistance
A free service that connects qualifying patients to prescription drug assistance programs.
www.PPARX.org

Cancer Care
Information, education, counseling and support for families dealing with cancer.
www.CancerCare.org

Patient Access Network
Assistance in paying out-of-pocket costs for underinsured people with life-threatening, chronic, and rare diseases and advocacy for improved access and affordability.
www.panfoundation.org

Patient Advocate Foundation
Professional case management services to Americans with chronic, life threatening, and debilitating illnesses.
www.PatientAdvocate.org

Patient Services Incorporated
Financial support and guidance for qualified patients with specific, rare chronic diseases.
www.patientservicesinc.org

HealthWell Foundation
Copay, deductible, and health care premium payment assistance for people with living with chronic and life-altering illnesses.
www.HealthWellFoundation.org

NeedyMeds
Information on health care programs for patients seeking affordable health care, offering direct assistance and facilitating programs.
www.NeedyMeds.org

The Centers for Medicare & Medicaid Services (CMS)
CMS covers over 130 million people in the United States through Medicare, Medicaid the Children’s Health Insurance Program and the Health Insurance Marketplace. The website provides extensive information and guidance for patients on all kinds of insurance.
www.cms.gov
**Affordable Care Act (ACA)**
The Affordable Care Act provides Americans with better health security by putting in place comprehensive health insurance reforms that will expand coverage, hold insurance companies accountable, lower health care costs, guarantee more choice, and enhance the quality of care for all Americans.

**Claim**
A bill that you or, most often, your doctor or health care professional, submits to your health insurance plan or to Medicare to ask for payment of covered medical services that you received.

**Coinsurance**
The amount you must pay for medical care after you have met your deductible. Typically, your plan will pay 80% of an approved amount, and your coinsurance will be 20%, but this may vary from plan to plan.

**Copay (or copayment)**
The flat fee you pay each time you receive medical care. For example, you may pay $25 each time you visit the doctor. Your plan pays the rest.

**Deductible**
The amount you must pay each year before your plan begins paying covered health care costs.

**Exclusions**
Services that are not covered by a health insurance plan (also known as “limitations”). These exclusions and limitations must be clearly spelled out in plan literature.

**Exclusive provider organization (EPO)**
A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan’s network (except in an emergency).

**Fee-for-service insurance**
Fee-for-service is a payment model where health services are billed for separately. This type of service is structured so that you and your plan each pay a portion of your health expenses, usually after you meet a yearly deductible. In most cases, you can choose any physician, hospital, or other provider (non-network based coverage).

**Flexible spending account (FSA)**
Employees deposit pre-tax dollars and draw down on them to pay qualified medical expenses during the year. Unused amounts are forfeited at the end of the year.

**Formulary**
A list of drugs that your insurance plan will cover and may include the amount you would pay for each drug.

**Group insurance**
Health plans offered to a group of individuals by an employer, association, union, or other entity.

**Health insurance exchange**
A marketplace where consumers can purchase insurance. There are two types of exchanges: The “American Health Benefits Exchange” for individuals and the “Small Business Health Options Program” (SHOP) for small employers. Each state may operate both exchanges separately, operate one combined exchange for both individuals and small groups, or decline to operate its own exchange altogether. Consumers in states that do not have their own exchange will still be able to purchase coverage, known as a “Qualified Health Plan,” through a federally facilitated exchange.

**Health maintenance organization (HMO)**
A form of managed care in which you receive all of your care from participating providers. You usually must obtain a referral from your primary care physician before you can see a specialist.
Health reimbursement arrangement
An account established by an employer to pay an employee’s medical expenses. Only the employer can contribute to a health reimbursement account.

Health savings account
An account established by an employer or an individual to save money toward medical expenses on a tax-free basis. Any balance remaining at the end of the year “rolls over” to the next year.

Health care network
A health care network is a list of doctors and health care providers plus hospitals, clinics, and pharmacies who have a contract to provide medical care to members of the network. Health care providers and others who do not have a contract with the plan are called “out-of-network.”

High-deductible health plan
A plan that provides comprehensive coverage for high-cost medical events. It features a high deductible and a limit on annual out-of-pocket expenses. This type of plan is usually coupled with a health savings account or a health spending account.

Indemnity insurance
Traditional fee-for-service health insurance that does not limit where a covered individual can get care.

Individual health insurance
Coverage purchased independently (not as part of a group), usually directly from an insurance company.

Medicaid
State administered program for economically disadvantaged. Funded by a combination of state and federal funds; “Aid for the Poor.”

Medicare
A federal insurance program that provides health care coverage to individuals age 65 and older and certain disabled people, such as those with end-stage renal disease and ALS.

Out-of-pocket costs
Health or prescription drug costs that you must pay on your own because they are not covered by Medicare or other insurance.

Out-of-pocket maximum (OOPM)
The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

Open enrollment
A set time of year when you can enroll in health insurance or change from one plan to another without benefit of a qualifying event (such as marriage, divorce, birth of a child or adoption, or death of a spouse). Open enrollment usually occurs late in the calendar year, although this may differ from one plan to another.

Point-of-service plan (POS)
A form of managed care plan in which primary care physicians coordinate patient care, but there is more flexibility in choosing doctors and hospitals than in an HMO.

Preferred provider organization (PPO)
A form of managed care in which you have more flexibility in choosing physicians and other providers than in an HMO. You can see both participating and non-participating providers, but your out-of-pocket expenses will be lower if you see only plan providers.

Premium
The amount you pay to belong to a health plan. If you have employer-sponsored health insurance, your share of premiums usually are deducted from your pay.

Primary care physician
Usually a family practice doctor, internist, obstetrician-gynecologist, or pediatrician. He or she is your first point of contact with the health care system, particularly if you are in a managed care plan.

Reasonable and customary charge
The prevailing cost of a medical service in a given geographic area.

Source: Agency for Healthcare Research and Quality (AHRQ) and Healthcare.gov, U.S. Dept. of Health and Human Services
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Points to Remember

• **Talk to your doctor or health care provider.** Talk to your health care provider right away if you have any questions about your health insurance coverage. Most offices have someone who can help you figure out your next steps if something is unclear.

• **Request a case manager.** Your insurance company may have a case manager to help you understand your insurance. Contact your case manager to get information about your health insurance claims and your policy.

• **Keep good records.** Each time you contact medical professionals or an insurance company, keep a record of the staff member you spoke with and the date of the conversation. Ask for copies of claim forms and other documentation. These notes and records will be important if you need to file an appeal.

• **Don’t be afraid to appeal if your claim is denied.** Appealing denied claims is common.

• **Seek help if you have trouble paying your bills.** There are many resources for patients who have a hard time paying their health care bills. Talk to your health care professional for advice, or contact one of the patient advocacy groups in the Patient Resources section of this booklet.