



# Understanding Your Healthcare Benefits 2023

Useful information about how health insurance helps you pay for treatment.



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# Health Insurance Basics

There are 2 types of healthcare plans:

## Private Health Insurance<sup>1</sup>

- Usually provided by an employer or individually purchased, typically referred to as commercial insurance

## Public Health Insurance<sup>1,2</sup>

- Provided by the government
- Examples include Medicare, and Medicaid

**NOTE:** How much you pay for healthcare and the amount of coverage you have depends on the type of insurance and the plan within that insurance.

**Both private and public healthcare plans typically provide 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.<sup>3</sup>



### The pharmacy benefit

typically covers prescription drugs taken by mouth, and self-administered injectable prescription drugs that are used at home.<sup>3</sup>



### Two more things to know:

1. Your healthcare plan pays a portion of your medical bills.<sup>1,2,4</sup> You usually have to pay part of the other costs for your healthcare. These are called **COINSURANCE**, **CO-PAYMENTS**, and **DEDUCTIBLE**.<sup>5</sup>
2. 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.<sup>1</sup> For example, a lower-cost healthcare 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.<sup>2,6</sup>

**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, plus any deductibles that you owe, and your plan pays the remaining amount.<sup>7</sup>

**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.<sup>7</sup>

**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.<sup>7</sup>

**PREMIUM:** The amount you pay for your health insurance every month.<sup>7</sup>



# Health Insurance Basics (cont)

Private (Commercial) Insurance <sup>1-3</sup>			
Refers to any health insurance plan you do not get from the government. You can buy health insurance directly from an insurance company or healthcare exchange. <sup>4</sup> With commercial insurance healthcare plans, if you pay higher premiums, typically you get more healthcare services and you may have less out-of-pocket costs.			
<b>Group Health Insurance</b> Employer-sponsored health plans	<b>Individually Purchased Insurance</b> You buy health insurance directly from an insurance company or healthcare exchange		
<b>Public (Federal or State) Insurance</b>	Medicare <sup>1,6,8</sup> covers people: <ul style="list-style-type: none"> <li>• Aged 65 or older</li> <li>• Under 65 years of age with certain disabilities</li> <li>• With end-stage renal (kidney) disease</li> </ul>		
<b>Medicare Part A</b> A medical benefit that covers hospital-related services, skilled nursing facilities, and certain other services and equipment	<b>Medicare Part B*</b> A medical benefit that covers medically necessary and preventive services, including doctor visits and drugs that must be given by a doctor	<b>Medicare Part C</b> Medicare Advantage Plans—allow Medicare benefits through <b>MANAGED CARE PLANS</b> ; these plans may include both medical and pharmacy benefits	<b>Medicare Part D</b> A pharmacy benefit that covers prescription drugs taken at home
Public health insurance is run by the government. However, some private companies contract with Medicare to provide all of your Part A and Part B benefits, with many of them also providing prescription drug coverage. These are called Medicare Advantage plans. Medicare Advantage plans are run by private insurance companies but abide by Medicare rules. However, you won't be covered by original Medicare if you opt for a Medicare Advantage plan. <sup>8</sup>			
*Medicare-eligible patients must enroll in Part B to receive Part B benefits.			
<b>Medicaid<sup>1,8,9</sup></b> <ul style="list-style-type: none"> <li>• Covers millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities</li> <li>• Medicaid is partly funded by the federal government and administered by states, according to federal requirements</li> </ul>	<b>Veterans Health Administration/Tricare DoD (Department of Defense)<sup>10,11</sup></b> Covers people who are or have been in the military, including: <table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top; width: 50%;"> <ul style="list-style-type: none"> <li>• Veterans</li> <li>• Active-duty service members</li> <li>• National Guard and Reserve members</li> </ul> </td> <td style="vertical-align: top; width: 50%;"> <ul style="list-style-type: none"> <li>• Retirees</li> <li>• Military families</li> </ul> </td> </tr> </table>	<ul style="list-style-type: none"> <li>• Veterans</li> <li>• Active-duty service members</li> <li>• National Guard and Reserve members</li> </ul>	<ul style="list-style-type: none"> <li>• Retirees</li> <li>• Military families</li> </ul>
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These charts include the most common types of insurance; they do not include all types.

**MANAGED CARE:** Managed care is a healthcare delivery system organized to manage cost, utilization, and quality by forming contract arrangements and setting prices for services.<sup>12</sup>

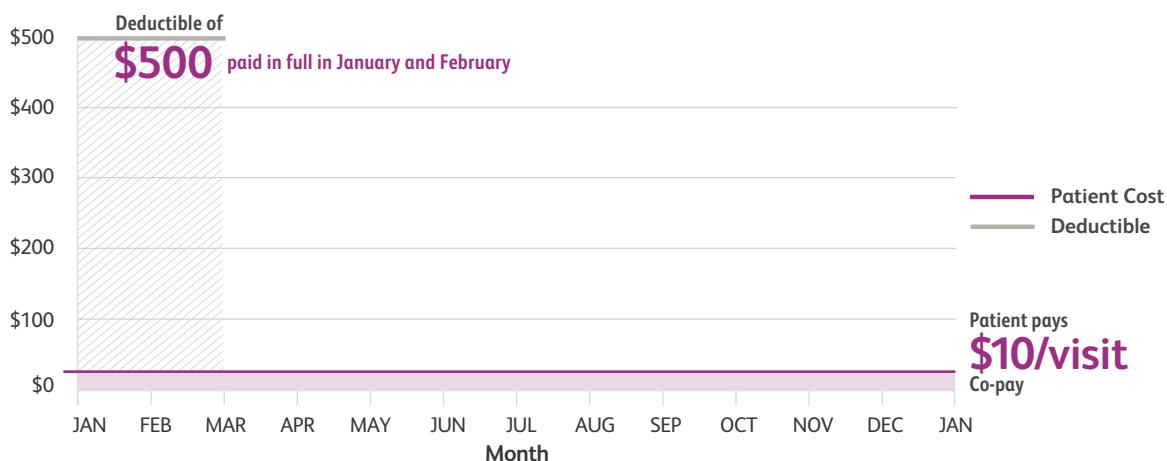


# What You Will Be Asked to Pay for Treatment

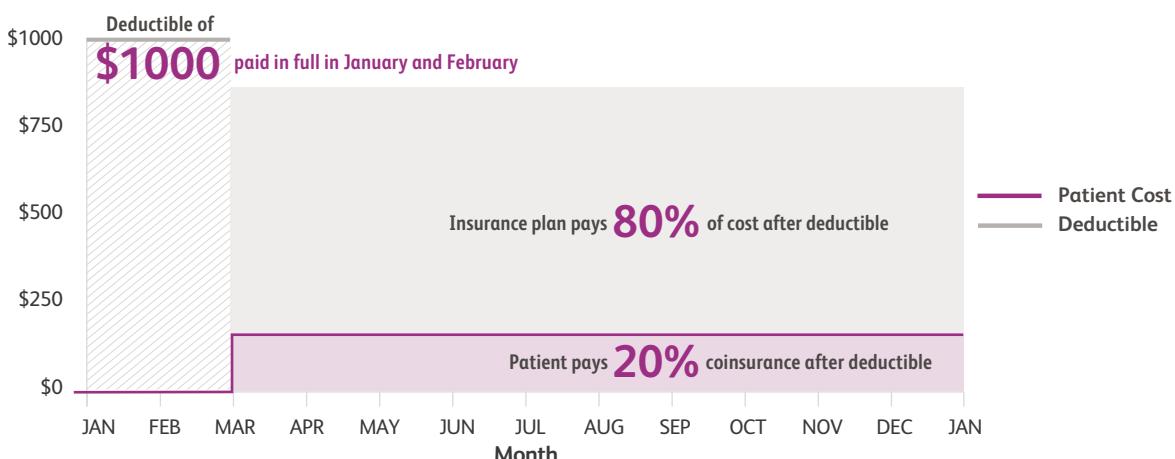
## The Amount You Will Pay For Your Treatment Depends On Your Healthcare Plan

The first thing you will pay for is your monthly premium, which we covered earlier. 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. You may have a separate deductible for your pharmacy benefit and medical benefit.<sup>7</sup>

In addition, you may have to pay a certain amount up front for each doctor visit or drug, called a **CO-PAY**, which is a type of cost-sharing in some health plans.<sup>7</sup> You pay a fixed amount (\$10, 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. The following example shows a patient with a \$500 deductible and a \$10 co-pay. The \$500 deductible in this example is paid in full during the first 2 months of the year. Once their deductible is met, the patient only pays the \$10 co-pay for each additional visit.



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. 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**.<sup>7</sup> The following example shows a patient with a \$1000 deductible and a 20% coinsurance. The \$1000 deductible in this example is paid in full during the first 2 months of the year. Once their deductible is met, the patient only pays 20% of the cost for each additional visit. The insurance plan pays the remaining 80%. So if the healthcare provider charges \$100 for the visit, the patient will pay \$20 and the insurance plan pays the remaining \$80.



**Your summary of benefits will tell you exactly what you need to pay for:** your premium, what your annual deductible is, your 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.<sup>8</sup>



# Treatment Approval Process

Many health plans require you to go through an approval process before starting treatment and throughout your 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.

## Precertification

This is a notification for non-urgent services, sent to a payer, informing the payer that the patient wants to have a service completed. This does not involve the patient's medical records.<sup>13</sup>

## Prior Authorization (PA)

Your health insurance or plan may require a prior authorization for certain services before you receive them, except in cases of an emergency. 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 the health plan will determine if this treatment will be covered.<sup>7,13</sup>

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).

If the health plan still denies coverage, you have another option depending on what type of coverage you have. If you have private insurance, your doctor's office can write a letter of medical necessity in attempt to appeal the decision. If you have Medicare, your doctor or you may ask for a coverage determination, which is a written explanation of your coverage benefits.<sup>14</sup>

In either instance, 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 can't take any of the less expensive drugs for the same condition<sup>14</sup>

# Understanding Your Explanation of Benefits (EOB) and Medicare Summary Notice (MSN)

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.<sup>8</sup> These statements are not bills.<sup>15</sup> 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. If your plan denies coverage, usually your doctor's office staff will file an appeal for you.

\*An example regarding medication coverage is shown on the following page.



# Paying for the Medicines You Need

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.

## Drugs Come in 3 Common Forms



**Oral drugs** (can be in the form of capsules, tablets, pills, or liquid) are usually taken at home



**Intravenous infusions** (abbreviated IV, meaning “into the veins”) are usually given at a clinic, hospital, or doctor’s office<sup>16,17</sup>



**Subcutaneous injections** (abbreviated SC, meaning “under the skin”) can be given in a doctor’s office or self-injected at home<sup>8,18</sup>

## Coverage for Oral Drugs



*If you are prescribed an oral drug, you will take this drug by mouth.  
No doctor’s appointment is necessary to take this medication. Certain oral drugs  
may need to be provided through a specialty pharmacy.*

## What Will You Pay for Each Oral Drug?<sup>8</sup>

Coverage for oral drugs is usually included in a health plan’s pharmacy benefits instead of medical benefits. Private insurance may be similar to public insurance, depending on the type of health plan you have—unless you have original Medicare, in which case they will be covered under Medicare Part D.

If you have Medicare (Parts A and B only), Medicaid, or another government-funded health plan, you may be eligible for assistance from third-party foundations.

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 of the cost. These amounts will change over the year depending on which phase of your drug benefit you are in.

**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.<sup>16,17</sup>

**ORAL DRUG:** A medicine taken by mouth, usually a tablet or capsule (pill) or a liquid.

**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.<sup>18</sup>



# Coverage for Oral Drugs (cont)

## Cost-Sharing With the Standard Medicare Part D Benefit in 2023<sup>19</sup>

Your plan may have different limits, but the 4-phase structure will probably follow the Part D standard benefit.

LEGEND:  Patient

 Medicare Part D Plan

 Manufacturer

 Government (Medicare)

### Phase 1:

#### Deductible Phase<sup>19</sup>

Health plans require you to pay the entire deductible amount yourself for covered prescription drugs before providing any financial coverage, including for specialty drugs.

- Your deductible depends on the Medicare Part D plan in which you are enrolled but will not exceed \$505 in 2023

 100%

### Phase 2:

#### Initial Coverage Phase<sup>20</sup>

Once you pay the deductible, you start to pay 25% of your prescription drug cost, and your Medicare Part D plan pays the remainder. How long you stay in the initial coverage period can depend on drug cost and the plan benefit structure.

 25% |  75%

### Phase 3:

#### Coverage Gap Phase (also called the Donut Hole)<sup>20</sup>

When you and your Medicare Part D plan jointly spend \$4,660 on prescription drugs, not including your Part D premium, you enter the Coverage Gap Phase but continue to pay no more than 25% of your prescription drug cost.

Brand-name  
drugs:

 25% |  70% |  5%

Generic  
drugs:

 25% |  75%

### Phase 4:

#### Catastrophic Coverage Phase<sup>20</sup>

When you and the manufacturer jointly spend \$7,400 on your prescription drugs, you will pay approximately 5% of your prescription costs for the remainder of the calendar year.

- For brand-name drugs, you will pay 5% of the prescription's cost or \$10.35, whichever is higher
- For generic drugs, you will pay 5% of the prescription's cost or \$4.15, whichever is higher

 ~5% |  80% |  ~15%



# Coverage for Subcutaneous (SC) Injection Drugs



*Some drugs can be given as subcutaneous (SC) injections, under your skin with a small needle, 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.<sup>8</sup>*

## 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. 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 on page 7).

# Coverage for Intravenous (IV) Infusion Drugs



*If you are prescribed a drug given by **intravenous (IV) infusion**, which means it is injected directly into your veins with a needle, it will most likely be given to you either in a hospital, clinic, or at your doctor's office.<sup>16,17</sup>*

## How Is Your IV Infusion Covered?

Coverage for IV infusions is usually included in a health plan's medical benefits instead of pharmacy benefits. Private insurance coverage may be similar to public insurance, depending on the type of health plan you have—unless you have original Medicare, with Part D coverage. Your infusion may be covered by Medicare Part A or B depending on where you receive the infusion. Also, 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.<sup>8</sup> Please see the following page for additional information on the **EXTRA HELP**, also known as Low-Income Subsidy (LIS), program.

## What Will You Pay for Each IV Drug?<sup>8</sup>

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. 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.<sup>8</sup>

**EXTRA HELP:** Extra Help is a Medicare program to help people with limited income and resources pay Medicare prescription drug costs.<sup>8</sup>

**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.<sup>16</sup>



# Coverage for Combination Therapies



*Some treatment options may require multiple drugs, such as two IV infusions or an IV infusion and an oral drug.*

## What Will You Pay for Combination Therapy?

Your treatment regimen may be covered by the pharmacy benefit, medical benefit, or both, depending on which drugs you receive. Your out-of-pocket costs may be different for each drug and you may receive those bills separately.

## Low-Income Subsidy (LIS), also referred to as Extra Help

The LIS may help eligible people with Medicare pay for prescription drugs, and can lower the costs of Medicare prescription drug coverage. To qualify for LIS, you must be receiving Medicare and have limited resources and income.<sup>21</sup>

### 2023 Maximum LIS Beneficiary Cost-Sharing<sup>22</sup>

LIS Category	Deductible	Copayment up to Out-of-Pocket Threshold <sup>a</sup>	Copayment above Out-of-Pocket Threshold <sup>a</sup>
Institutionalized Full-Benefit Dual Eligible; or Beneficiaries Receiving Home- and Community-based Services	\$0	\$0	\$0
Full-Benefit Dual Eligible ≤ 100% federal poverty limit (FPL)	\$0	\$1.45 generic, \$4.30	\$0
Full-Benefit Dual Eligible > 100% FPL; or Medicare Saving Program Participant (QMB only, SLMB-only, or QI); or Supplemental Security Income (but not Medicaid) Recipient; or Applicant < 135% FPL with resources ≤ \$9,900 (\$15,600 if married) <sup>b</sup>	\$0	\$4.15 generic, \$10.35 brand	\$0
Applicant < 150% FPL with resources between \$9,900 - \$15,510 (\$15,600 - \$30,950 if married) <sup>b</sup>	\$104	15%	\$4.15 generic; \$10.35 brand

<sup>a</sup>The out-of-pocket threshold is \$7,400 for 2023.

<sup>b</sup>The resource limits displayed include \$1,500 per person for burial expenses. For beneficiaries that did not notify SSA that they expect to use some of their resources for burial expenses, the applicable resource limit is \$9,900 (\$15,600 if married) for the full low-income subsidy and \$15,510 for the partial subsidy (\$30,950 if married). QMB = qualified Medicare beneficiary; SLMB = specified low-income Medicare beneficiaries; QI = qualifying individuals.

**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.<sup>23</sup>

# BMS Access Support®



For patients who have been prescribed a BMS Medication, BMS Access Support 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

The BMS Co-Pay Assistance Program helps eligible commercially insured patients who have been prescribed select BMS medications with out-of-pocket deductibles, co-pays, or coinsurance requirements.

### \$0 Co-Pay for select IV Medications



Co-pay\*:

**\$0**

per dose

Annual maximum benefit:  
**\$10K-\$25K**

### Co-Pay Assistance for select Oral Medications



Co-pay\*:

**\$0**

per one-month supply

Annual maximum benefit:  
**\$15K**



Eligible patients can visit [www.BMSAccessSupport.com](http://www.BMSAccessSupport.com) to activate a co-pay card or call BMS Access Support at 1-800-861-0048 8AM–8PM EST, Monday–Friday.

\*Terms and Conditions Include:

- Patients must have commercial (private) insurance that covers the prescribed Bristol Myers Squibb medication, but the insurance does not cover the full cost; that is, the patient has a co-pay obligation (out-of-pocket cost) for the prescribed medication
- Patients are not participating in any state or federal healthcare program, including Medicaid, Medicare, Medigap, CHAMPUS, TriCare, Veterans Affairs (VA), or Department of Defense (DoD), or any state, patient, or pharmaceutical assistance program. Patients who move from commercial (private) insurance to a state of federal healthcare program will no longer be eligible
- Patients must live in the United States or Puerto Rico

## BMS Access Support<sup>®</sup> (cont)

### For Patients With Public Health Insurance

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- 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

### For Patients Without Prescription Drug Coverage

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- BMS Access Support can make a referral to independent charitable foundations, including The Bristol Myers Squibb Patient Assistance Foundation (BMSPAF) that may be able to provide assistance
- 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; for more information, call BMS Access Support at 1-800-861-0048



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## Notes

## Notes



## Access Support® >

# If You Have Questions About Your Insurance or Coverage, We May Be Able To Help

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 Bristol Myers Squibb Access Support at **1-800-861-0048**, 8 AM to 8 PM ET, Monday–Friday, to speak with a regionally assigned specialist



Visit [www.BMSAccessSupport.com](http://www.BMSAccessSupport.com) for information and resources, including the enrollment form, with access to Bristol Myers Squibb products

