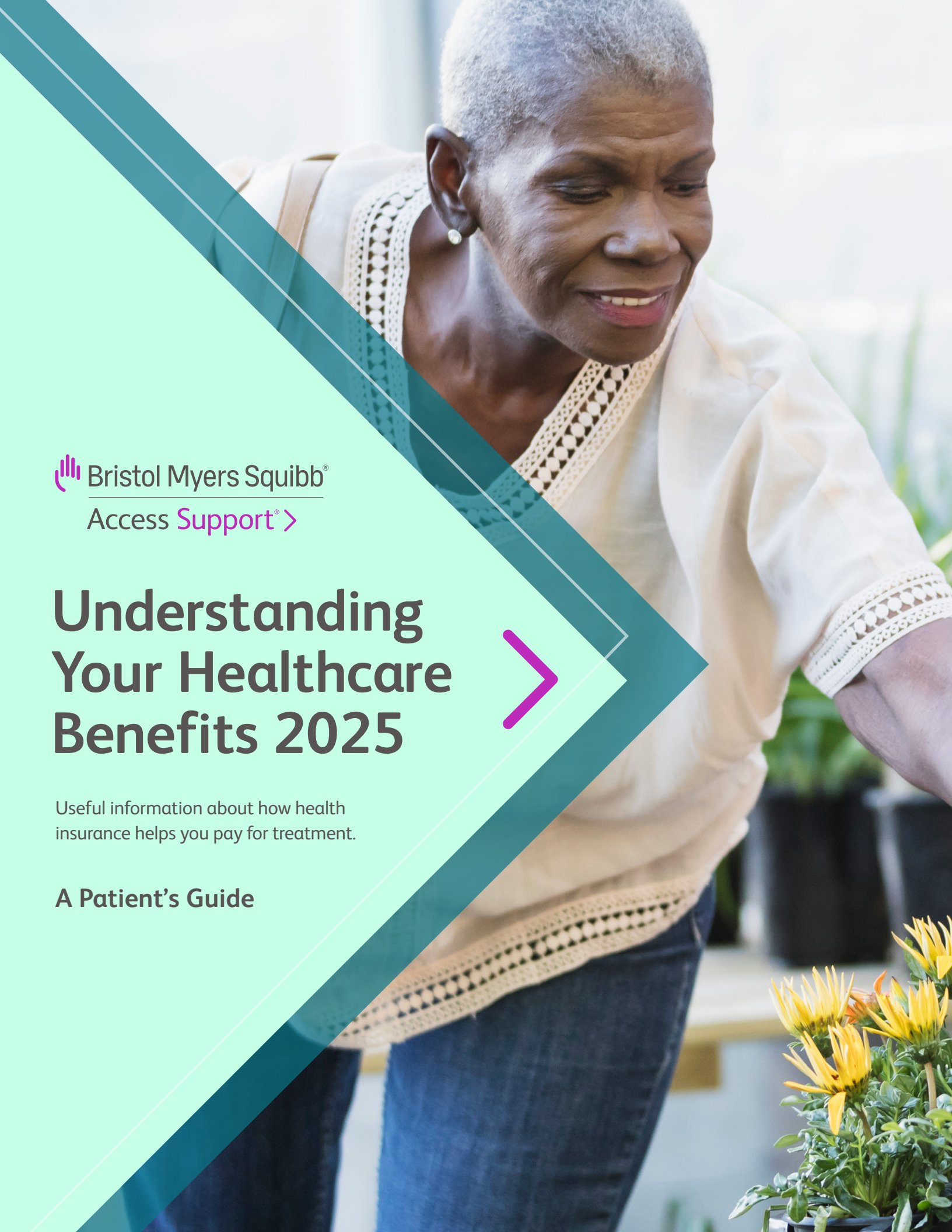


Bristol Myers Squibb®
Access Support®

Understanding Your Healthcare Benefits 2025

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

A Patient's Guide

Table of Contents

Health Insurance Basics

There are 2 types of healthcare plans:

Private Health Insurance[1]

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

Public Health Insurance[1,2]

Provided by the government, examples include Medicare and Medicaid

NOTE: How much you pay for healthcare and the amount of coverage you have depend 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.[3]

The pharmacy benefit

typically covers prescription drugs taken by mouth, and self-administered injectable prescription drugs that are used at home.[3]

Two more things to know:

1. Your healthcare plan pays a portion of your medical bills.[1,2,4] You usually have to pay part of the other costs for your healthcare. These are called **COINSURANCE**, **CO-PAYMENTS**, and **DEDUCTIBLE**.[5]
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.[1] 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.[2,6]

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.[7]

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.[7]

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.[7]

PREMIUM: The amount you pay for your health insurance every month.[7]

Health Insurance Basics (cont.)

Private (Commerical) Insurance[1-3]

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.[4] With commercial insurance healthcare plans, if you pay higher premiums, typically you get more healthcare services and you may have fewer out-of-pocket costs.

- **Group Health Insurance**
  Employer-sponsored health plans
- **Individually Purchased Insurance**
  You buy health insurance directly from an insurance company or healthcare exchange

Public (Federal or State) Insurance

- **Medicare[1,6,8]**
  Covers people:
  - Aged 65 or older
  - Under 65 years of age with certain disabilities
  - With end-stage renal (kidney) disease

  - **Medicare Part A**
    A medical benefit that covers hospital-related services, skilled nursing facilities, and certain other services and equipment
  - **Medicare Part B***
    A medical benefit that covers medically necessary and preventive services, including doctor visits and drugs that must be given by a doctor
  - **Medicare Part C†**
    Medicare Advantage Plans that allow Medicare benefits through **MANAGED CARE PLANS**; these plans may include both medical and pharmacy benefits
  - **Medicare Part D**
    A pharmacy benefit that covers prescription drugs taken at home

- **Medicaid[1,8,9]**
  - Covers millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities
  - Is partly funded by the federal government and administered by states, according to federal requirements

- **Veterans Health Administration/Tricare DoD (Department of Defense)[10,11]**
  Covers people who are or have been in the military, including:
  - Veterans
  - Active-duty service members
  - National Guard and Reserve members
  - Retirees
  - Military families

These charts include the most common types of insurance; they do not include all types.

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

†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.[8]

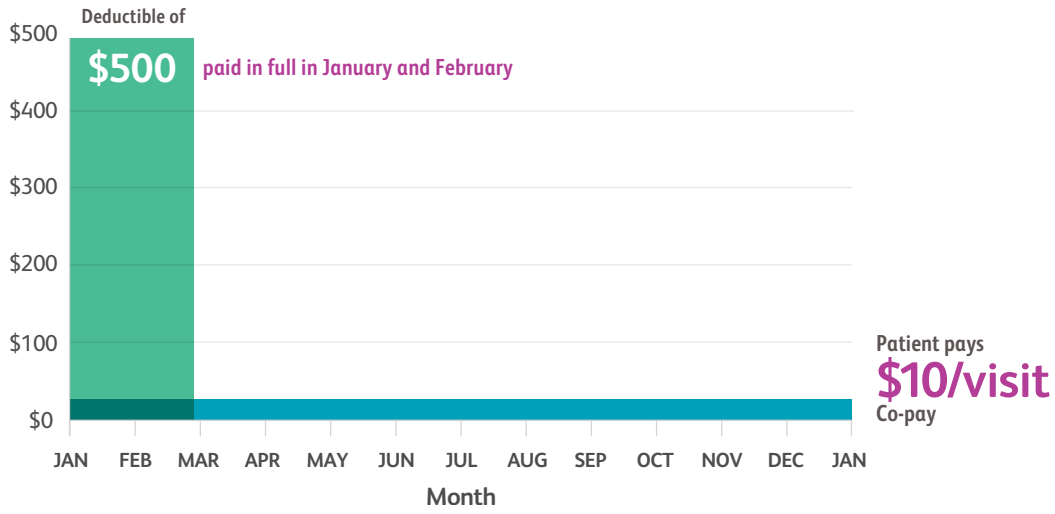
MANAGED CARE: Managed care is a healthcare delivery system organized to manage cost, utilization, and quality by forming contract arrangements and setting prices for services.[12]

What You Will Be Asked to Pay for Treatment

- **MONTHLY PREMIUM:** the amount you pay for your health insurance every month
- **DEDUCTIBLE:** the amount of money you must pay each year for covered services and treatments before your insurance company begins to pay for them[7]
- **CO-PAY:** the amount you may be required to pay up front for each doctor visit or drug.[7] You pay a fixed amount for a covered healthcare service or drug after you've paid your deductible
- **COINSURANCE:** the amount you may be required to pay for a service once your deductible is met.[7] Some health plans require coinsurance instead of co-pay

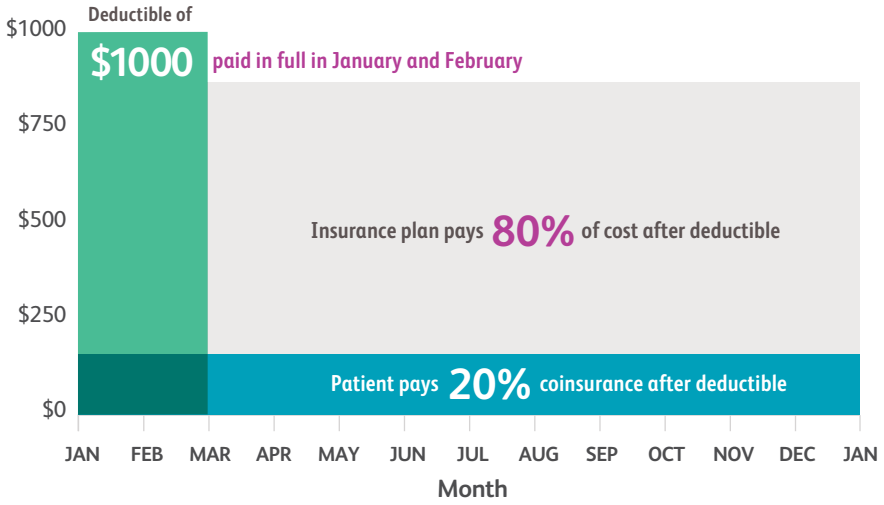
Example 1:

Patient 1 has a **$500 deductible** and a **$10 co-pay**. The example illustrates that the patient only pays the **$10 co-pay for each additional visit** once their deductible is met.



Example 2:

Patient 2 has a **$1,000 deductible** and a **20% coinsurance**. The example illustrates that the patient only pays **20% of the cost for each additional visit** and the insurance plan pays the remaining **80% once their deductible is met**.



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 cost. 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 cost of covered benefits.*[8]

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.[13]

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.[7,13]

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).

In the Event of a Coverage Denial

- 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, you or your doctor may ask for a coverage determination, which is a written explanation of your coverage benefits.[14]
- 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[14]

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.[8] These statements are not bills.[15] 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.[16,17]

Subcutaneous injections (abbreviated SC, meaning "under the skin") can be given in a doctor's office or self-injected at home.[8,18]

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?[8]

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.

Starting in 2025, you can enroll into Medicare Prescription Payment Plan to help manage out-of-pocket costs by spreading the cost across the calendar year. Please see page 9 for additional information on the Medicare Prescription Payment Plan.

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.[8] Please see page 11 for additional information on the **EXTRA HELP**, also known as Low-Income Subsidy (LIS), program.

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.[16,17]

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.[18]

Coverage for Oral Drugs (cont.)

Cost-Sharing With the Standard Medicare Part D Benefit in 2025[19,20]

Your plan may have different limits, but the 3-phase structure will probably follow the Part D standard benefit.

LEGEND: Patient | Medicare Part D Plan | Manufacturer | Government (Medicare)

Phase 1:

Deductible Phase[19,20]

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 **$590** in **2025**.

100%	

Phase 2:

Initial Coverage Phase[20]

Once you pay the deductible, you start to pay 25% of your prescription drug cost. For brand-name drugs, your Medicare Part D plan pays 65% and the manufacturer pays 10%. For generic drugs, the Medicare Part D plan pays 75%. This phase will end when your total out-of-pocket expense reaches the annual threshold of **$2,000** for **2025**.

Brand-name drugs:	25%	65%	10%
Generic drugs:	25%	75%	

Phase 3:

Catastrophic Coverage Phase[20]

Once entering the catastrophic phase, **you have no cost sharing.** Your Medicare Part D plan will pay 60% of the cost. For brand-name drugs, manufacturer will pay 20% and the government will pay 20%. For generic drugs, the government will pay 40% of the cost.

Brand-name drugs:	60%	20%	20%
Generic drugs:	60%	40%	

Medicare Prescription Payment Plan[21-23]

- The Medicare Prescription Payment Plan is a **voluntary payment option provided by a patient's Medicare Part D insurance plan to help them manage their out-of-pocket (OOP) drug costs by spreading the payment over the course of the plan year (January-December)** in the form of monthly payments. This option may help patients manage their drug expenses, but it does not save them money or lower their OOP drug cost.
- When enrolled into this payment plan and a patient fills a prescription covered by Part D, their OOP cost at the pharmacy will be **$0**. Instead, their Part D plan will bill them monthly for any cost-sharing they incur while enrolled in the program. The monthly bill is based on the cost of the prescription plus any previous months' balance (if any) divided by the number of months left in the year.
- **Medicare Prescription Payment Plan participation and termination are voluntary, at no cost to patients.**

Who can apply?

All patients enrolled in or eligible for Medicare Part D can apply to participate in the Medicare Prescription Payment Plan program.

While this program is available to anyone with Medicare Part D, **patients taking high-cost drugs earlier in the plan year are generally more likely to benefit.**

CMS has stated that, it is more advantageous for patients who are eligible for Low-Income Subsidy (LIS) to enroll in LIS than participate in the Medicare Prescription Payment Plan, though eligible patients can enroll in both.

When to apply?

Patients may opt into the Medicare Prescription Payment Plan program:
- During Medicare Open Enrollment: October 15, 2024 – December 7, 2024
- Prior to the beginning of the plan year or in any month during the plan year

In 2025, patients who choose to enroll at the time of filling a prescription may have to return to the pharmacy on another day to collect their medicine after receiving an enrollment confirmation from their Part D plan (typically within 24 hours of application).

How to apply?

Patients can apply to the Medicare Prescription Payment Plan program, as directed by their Part D plan sponsors, through:

- An election request form during enrollment
- By mail with a paper election form
- By phone as directed by a Part D plan
- Online, as directed by the Part D plan

Patients can call **1-800-MEDICARE (1-800-633-4227)** if they need help contacting their Part D plan.

Enrolling in Medicare Prescription Payment Plan program early, *before* incurring high OOP cost, allows patients to:

- **Have timely access to their medication without delay**
- **Have lower monthly payment by spreading OOP costs over a longer period**

Medicare Prescription Payment Plan (cont.)

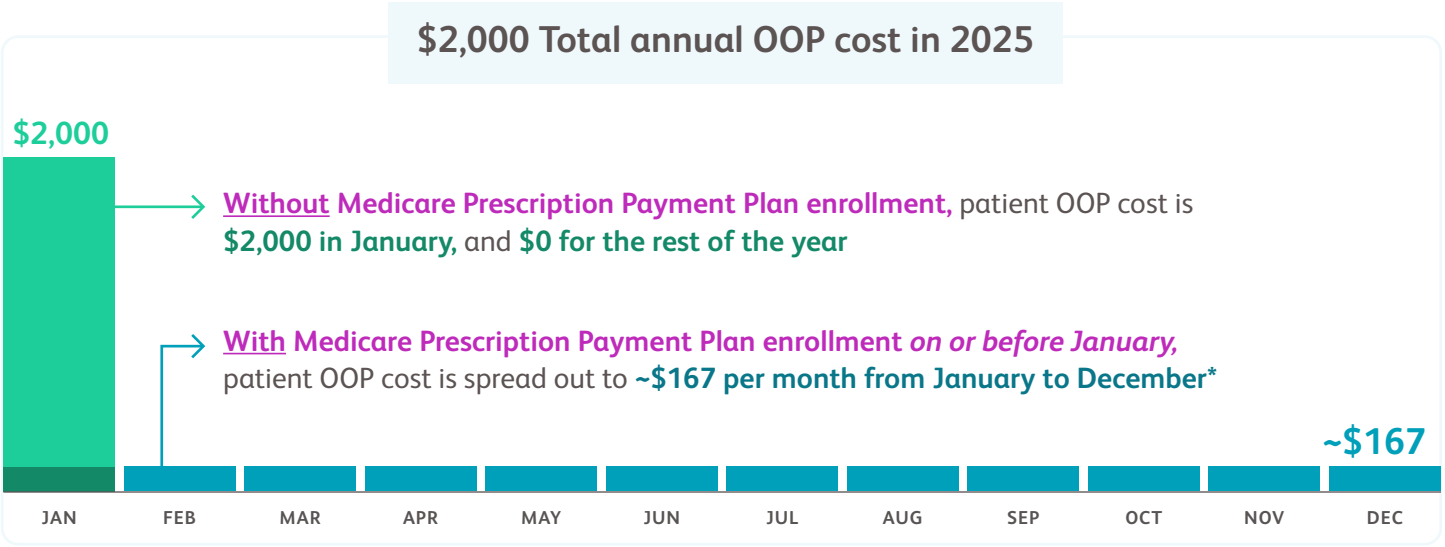
Patient cost journey examples

The cost of a specialty drug, regardless of drug price, goes through the 3 phases of Medicare Part D in 2025.

Note: The following are hypothetical patients and cost calculations. All costs presented in these examples are subject to change based on individual Part D plans, geography, and costs associated with healthcare facilities. Medicare Part D premiums are not included in the cost analysis.

Patient 1

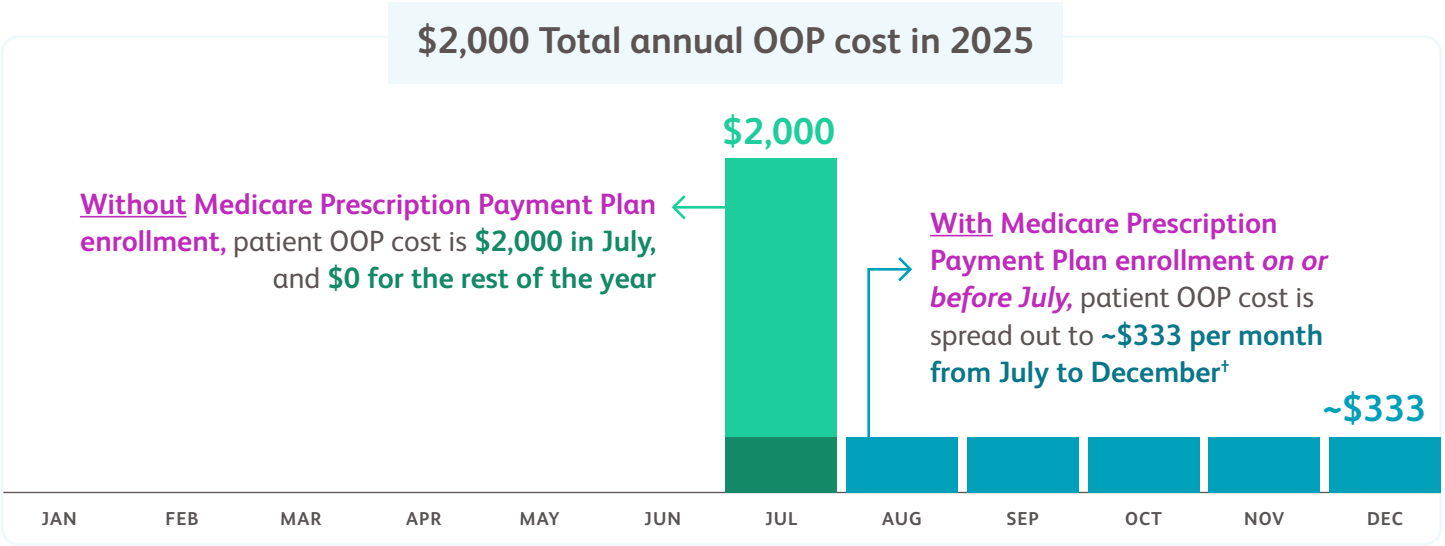
Patient 1 is prescribed a brand-name specialty drug called Drug X in **January 2025.** Drug X has a price of $300,000/year ($25,000/month), but that is not what they actually pay. The following example illustrates what Patient 1 would pay monthly.



*Assume patient does not have any out-of-pocket cost incurred prior to the prescription fill for Drug X in January.

Patient 2

Patient 2 is prescribed a brand-name specialty drug called Drug X in **July 2025.** Drug X has a price of $300,000/year ($25,000/month), but that is not what they actually pay. The following example illustrates what Patient 2 would pay monthly.



†Assume patient does not have any out-of-pocket cost incurred prior to the prescription fill for Drug X in July.

Low-Income Subsidy (LIS), Also Referred to as Extra Help

The Low-Income Subsidy (LIS) may help eligible people with Medicare pay for prescription drugs, and can lower the costs of Medicare prescription drug coverage. People who qualify may be able to pay less than $13 per month for certain drugs.[24]

To qualify for LIS, you must:[25]

- Be enrolled in a Medicare prescription drug plan
- Live in one of the 50 states or the District of Columbia
- Have limited income and resources*

To view the most recent federal poverty level (FPL), as well as calculations of the income limits used to determine eligibility for **Extra Help,** visit **aspe.hhs.gov/poverty**.

*Subject to annual changes

If you have Medicare and Medicaid (dual eligible), receive Supplemental Security Income (SSI), or belong to an eligible Medicare Savings Program, you automatically qualify for **Extra Help**, regardless of whether you meet the other requirements.[24]

For patients who are dual eligible, and are institutionalized or receiving home or community-based services, there is no deductible or co-pay requirement.

For other patients who may qualify for LIS, depending on income and resource level and other factors, you may pay $1.60 or $4.90 per prescription for a generic or $4.80 or $12.15 per prescription for a brand-name drug.

How do I get Extra Help?

To see if you qualify to receive Extra Help, you'll need to submit an application to the Social Security Administration (SSA). **Even if you aren't sure whether you qualify for Extra Help, you can still submit an application.** The SSA will review your application and determine how much assistance, if any, you are eligible to receive from the Extra Help program.

You can apply for Extra Help in any of the following ways:

Online at
ssa.gov/extrahelp

By phone at **800-772-1213**
(TTY 800-325-0778)

At your
local SSA office

EXTRA HELP: Extra Help is a Medicare program to help people with limited income and resources pay Medicare prescription drug costs.[8]

Coverage for Subcutaneous (SC) Injection Drugs

*Some drugs can be given as **subcutaneous (SC) injections**, under your skin with a small needle. 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.*[8]

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, the coverage is the same as for an oral drug (see Coverage for Oral Drugs section on page 8).

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 in a hospital, clinic, or at your doctor's office.*[16,17]

How Is Your IV Infusion Covered?

Coverage for IV infusions is usually included in a health plan's medical benefits. If you have Medicare, your infusion may be covered by Medicare Part A or B, depending on where you receive the infusion. Private insurance may be similar to public insurance, depending on the type of health plan you have.

What Will You Pay for Each IV Drug?[8]

Typically, you will pay a co-pay or coinsurance for the visit when you receive your infusion. If you are enrolled in Medicare Part B with no extra insurance coverage, you will be responsible for 20% coinsurance for each drug, after the annual deductible is paid.

*If you have Medicare Part B and choose to sign up for supplemental **Medigap-type** coverage for additional benefits, you may pay $0 for the drug after the deductible is paid.*[8]

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.

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.[26]

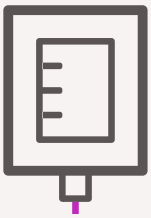
Financial Support Options

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 Access Support® 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 Physician-Administered Medications



Co-pay*:
$0
per dose

Co-Pay Assistance for Select Oral Medications

Co-pay*:
$0
per one-month supply

Eligible patients can visit **www.BMSAccessSupport.com** to activate a co-pay card for select medications, or call BMS Access Support at **1-800-861-0048**, 8 AM-8 PM ET, Monday–Friday for more information.

*Restrictions apply. Please see full Terms and Conditions, including complete eligibility requirements, by clicking the links below:
- For BMS physician-administered medications, click here
- For BMS oral medications, click here
The accurate completion of reimbursement- or coverage-related documentation is the responsibility of the healthcare provider and patient. Bristol Myers Squibb and its agents make no guarantee regarding reimbursement for any service or item.

Financial Support Options (cont.)

For Patients With Public Health Insurance

- If you have government insurance, such as Medicare, Medicaid, and TRICARE, these programs may cover part of your medication costs. In some cases, you will have to pay for the rest. If you have government insurance, you are not eligible for co-pay assistance programs sponsored by BMS. However, there are independent charitable foundations that may be able to help.
- BMS Access Support may be able to provide information about independent charitable foundations that may be able to provide financial support. It is important to note that these charitable foundations are independent from Bristol Myers Squibb Company. Each foundation has its own eligibility criteria and evaluation process. Bristol Myers Squibb cannot guarantee that a patient will receive assistance. It is important to note that these charitable foundations are independent from Bristol Myers Squibb Company. Each foundation has its own eligibility criteria and evaluation process. Bristol Myers Squibb cannot guarantee that a patient will receive assistance.

For Patients Without Prescription Drug Coverage

- If you don't have insurance, we may be able to provide you with information to help you on your treatment journey.
- Health plans available under the Affordable Care Act may be able to help you pay for your healthcare, including prescription medications.
- BMS Access Support can make a referral to independent charitable foundations that may be able to provide financial support. It is important to note that these charitable foundations are independent from Bristol Myers Squibb Company. Each foundation has its own eligibility criteria and evaluation process. Bristol Myers Squibb cannot guarantee that a patient will receive assistance.

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Notes

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.

Looking for support? We're here for you.

Coverage assistance, educational resources, and financial support options may be available through **BMS Access Support®**

Call a Patient Access Specialist at **1-800-861-0048**, 8 AM to 8 PM ET, Monday - Friday

Visit **www.BMSAccessSupport.com**

The accurate completion of reimbursement- or coverage-related documentation is the responsibility of the healthcare provider and patient. Bristol Myers Squibb and its agents make no guarantee regarding reimbursement for any service or item.

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