Understanding Your Healthcare Benefits

An educational guide about health insurance

MERCK

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HEALTH INSURANCE 101

What is health insurance?

Health insurance is an agreement in which a health insurer or company pays some or all of a patient's healthcare costs in exchange for a fee, which is called a **premium**.[1]

A **private health insurance plan** is marketed by the private health insurance industry. These plans can be employer-sponsored or can be purchased directly by the consumer.[2]

A **public health insurance plan** is a plan in which the US federal, state, or local government pays some or all of a patient's healthcare costs. The two main types of public health insurance are **Medicare** and **Medicaid**.[3]

Understanding what you will be expected to pay

- **Premium** – The amount of money that you pay for your health insurance plan each month.[4]
- **Deductible** – In addition to your premium, this is the amount that you may pay for any covered healthcare services before your insurance plan begins paying.[4,5]
- **Co-payments** – A fixed cost that you are expected to pay for a covered healthcare service after you've paid your deductible. Also referred to as "co-pays," these fees can vary for different services within the same plan.[6]
- **Co-insurance** – Like co-pays, co-insurance is an amount that you are expected to pay after you have paid your deductible. Unlike co-pays, co-insurance is a percentage of the cost of a covered healthcare service instead of a fixed rate.[7]

Two types of benefits are provided through health insurance:

1. A **medical benefit** covers physician and hospital services, including doctor visits, medications administered by a provider, and certain home services, among others.[8]
2. A **pharmacy benefit or prescription drug benefit** typically covers any medications that a patient can self-administer at home or have administered at the provider's office or facility.[8]

Some health plans may require you to get their approval before you receive a service or fill a prescription for your treatment to be covered by your plan. This is known as **prior authorization** and helps to make sure that drug benefits are administered as intended. It also makes sure that consumers under a plan receive safe, effective medication therapy for their condition with the greatest value.[9]

UNDERSTANDING WHAT MEDICARE COVERS

Medicare has 4 parts, each of which helps cover a different aspect of your care:

- **Medicare Part A (Hospital Insurance):** Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home healthcare.[10]
- **Medicare Part B (Medical Insurance):** Medicare medical insurance that helps pay for services from doctors and other healthcare providers, outpatient hospital care, durable medical equipment, some medical services, and many preventive services (like screening, shots or vaccines, and yearly "Wellness" visits) that are not covered by Part A.[10]
- **Medicare Part C (Medicare Advantage Plans):** Plans offered by Medicare-approved private companies. These bundled plans cover all of your Part A and Part B benefits and usually Part D.[10]
- **Medicare Part D (Medicare Drug Benefit):** Optional benefits for prescription drugs not covered under Medicare Part B that are available to Medicare beneficiaries for an additional charge. This coverage is offered by health insurance companies and other private companies approved by Medicare.[10]

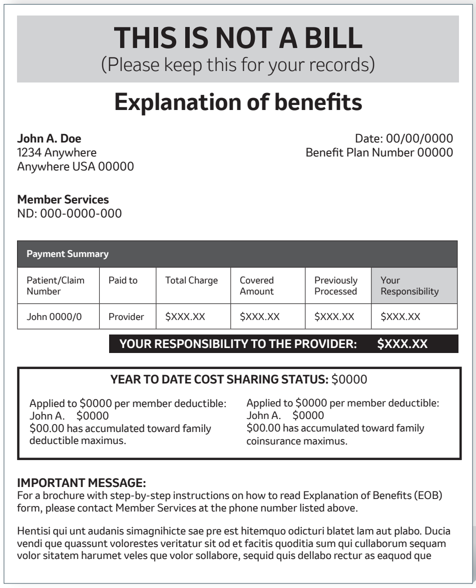
UNDERSTANDING WHAT YOU WILL PAY

Depending on the type of health insurance you have, your health plan will send you an explanation of benefits or a Medicare Summary Notice after receiving treatment. These are not bills; rather, they show what your health plan paid and any remaining balance you may owe your healthcare provider.[10]

Explanation of Benefits

An **explanation of benefits (EOB)** is a written document from an insurance company regarding the payment status or denial of a claim. It will contain a detailed explanation of what has already been paid and any balance that might remain. Sometimes, this document will be accompanied by a benefits check, but typically, the insurer will send payments directly to the medical provider.

It is important to keep in mind that the EOB is *not* a bill. If you still owe money after the insurance company has sent its payment, your provider will send a separate bill.[11]



THIS IS NOT A BILL
(Please keep this for your records)

Explanation of benefits

John A. Doe
1234 Anywhere
Anywhere USA 00000

Date: 00/00/0000
Benefit Plan Number 00000

Member Services
ND: 000-0000-000

Payment Summary

Patient/Claim Number	Paid to	Total Charge	Covered Amount	Previously Processed	Your Responsibility
John 0000/0	Provider	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX

YOUR RESPONSIBILITY TO THE PROVIDER: $XXX.XX

YEAR TO DATE COST SHARING STATUS: $0000

Applied to $0000 per member deductible:
John A. $0000
$00.00 has accumulated toward family deductible maximus.

Applied to $0000 per member deductible:
John A. $0000
$00.00 has accumulated toward family coinsurance maximus.

IMPORTANT MESSAGE:
For a brochure with step-by-step instructions on how to read Explanation of Benefits (EOB) form, please contact Member Services at the phone number listed above.

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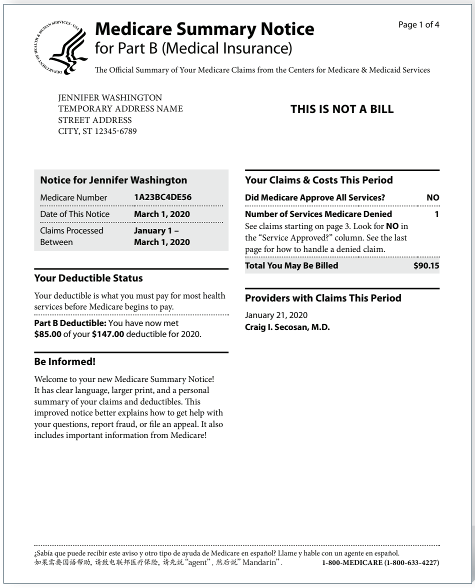
If your insurance plan decides not to cover a treatment that you feel should be covered, you can submit a request for your health insurance company to review that decision; this is known as an **appeal**.[10]

Medicare Summary Notice

If you are under Original Medicare, you will receive a **Medicare Summary Notice (MSN)** containing a detailed list of all services billed to Medicare. A Medicare contractor will send one to you once every 3 months. It's not a bill though you can request to receive it monthly. It is important to review your MSN carefully to make sure that the services, equipment, and supplies listed are accurate. The MSN will also show how to file an appeal if you disagree with Medicare's decision to not cover any service or treatment.[10]



Medicare Summary Notice
for Part B (Medical Insurance)

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The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

JENNIFER WASHINGTON
TEMPORARY ADDRESS NAME
STREET ADDRESS
CITY, ST 12345-6789

THIS IS NOT A BILL

Notice for Jennifer Washington

Medicare Number	**1A23BC4DE56**
Date of This Notice	**March 1, 2020**
Claims Processed Between	**January 1 – March 1, 2020**

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met **$85.00** of your **$147.00** deductible for 2020.

Be Informed!

Welcome to your new Medicare Summary Notice! It has clear language, larger print, and a personal summary of your claims and deductibles. This improved notice better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare!

Your Claims & Costs This Period

Did Medicare Approve All Services? **NO**

Number of Services Medicare Denied **1**
See claims starting on page 3. Look for **NO** in the "Service Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed **$90.15**

Providers with Claims This Period

January 21, 2020
Craig I. Secosan, M.D.

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
如果需要国语帮助，请致电联邦医疗保险，请先说"agent"，然后说"Mandarin". **1-800-MEDICARE (1-800-633-4227)**

HANDLING DISPUTES RELATED TO YOUR TREATMENT

In the event that your insurance plan denies payment for a claim, you have the right to request an **internal appeal**. Upon receiving your request, the insurance plan is required to review and provide a reason for their decision. If, after requesting an appeal, your insurance company still denies payment or coverage, you may then request an **external review**, where an independent third party will decide to either approve or reverse the insurance plan's decision.[12]

GLOSSARY
Terms With Important Information That Patients Should Know

Appeal: A request for your health insurance company to review a decision that denies a benefit or payment.[13]

Beneficiary: Anyone who is covered by a health plan. This could be the person who signed up for the plan or a dependent.[14]

Benefits: The money or services provided by an insurance policy. In a health plan, benefits are the services that your health plan has agreed to cover.[15]

Care Plan: A written plan for your care indicating what services you will receive to achieve and maintain your best physical, mental, and social well-being.[16]

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare program. In addition, CMS works with the governments of individual states to run the Medicaid program.[17]

Claim: A request for payment that you or your healthcare provider submits to your health plan insurer when you receive items or services that you think are covered.[18]

Coverage Gap (also called Donut Hole): Under Medicare Part D prescription drug coverage, a coverage gap occurs when Medicare temporarily stops paying for certain prescriptions after the initial coverage limit has been met. Beneficiaries within the coverage gap are responsible for paying the entire cost of medications until reaching the threshold for catastrophic coverage.[19]

Drug Tiers: Within a health plan, prescription drugs are divided into drug tiers. Most health plans have either 3 or 4 drug tiers, which may determine how much you pay out of pocket, such as a co-pay or co-insurance.[20]

Dual-Eligible: Individuals who receive both Medicare and Medicaid benefits are dual-eligible beneficiaries. The two programs cover many of the same services, but Medicare pays first for the Medicare-covered services that are also covered by Medicaid.[21]

Eligibility: The process that determines whether you qualify to participate in healthcare coverage. Eligibility is determined by the State.[22]

Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.[10]

Insurer: *See Payer.*

Managed Care: A medical delivery system that attempts to manage the quality and cost of medical services that individuals receive. Most managed care systems utilize a health maintenance organization (HMO), an exclusive provider organization (EPO), a preferred provider organization (PPO), or a point of service (POS) network design, limiting to varying degrees the number of providers from which a patient can choose, whether the patient must use a primary care physician, and whether out-of-network care is covered under the plan.[23]

Medicaid: A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state.[10]

Medicare: Federal health insurance for people 65 or older, and some people under 65 with certain disabilities or conditions.[24]

Medicare Savings Programs: State programs that provide help with additional Medicare costs.[10]

Medigap Plans: A Medicare supplemental insurance policy sold by private health insurance companies to fill “gaps” in Original Medicare coverage. Generally, when you buy a Medigap policy, you must have Medicare Part A and Part B.[10,25]

Network: The facilities, providers, and suppliers that your health insurer or plan has contracted with to provide healthcare services.[26]

Out-of-Pocket Costs: Healthcare costs that you must pay on your own because they are not covered by your health insurance.[27]

Payer: In healthcare, an entity that assumes the risk of paying for medical services. This can be an uninsured patient, a self-insured employer, a health plan, or a health maintenance organization.[28]

Preferred Provider Organization (PPO): A type of managed care in which you use doctors, hospitals, and providers belonging to the network. You may use doctors, hospitals, and providers outside of the network for an additional cost.[29]

Prior Authorization: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.[30]

Referral: Certification from a provider stating that you are allowed to receive additional plan-covered services, such as a particular treatment or an appointment with a specialist. Some health plans require referrals for coverage.[31]

Specialty Pharmacy: A state-licensed pharmacy that solely or largely provides medications for people with serious health conditions requiring complex therapies.[32]

TRICARE: A healthcare program for active duty and retired uniformed services members and their families.[33]

REFERENCES

1. Health coverage basics. Centers for Medicare & Medicaid Services. Accessed November 10, 2023. https://www.cms.gov/marketplace/technical-assistance-resources/training-materials/health-coverage-basics-training.pdf
2. Private health insurance. Healthinsurance.org. Accessed November 10, 2023. https://www.healthinsurance.org/glossary/private-health-insurance
3. Public health insurance. Dictionary of Cancer Terms. National Cancer Institute. Accessed November 10, 2023. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/public-health-insurance
4. Premium. HealthCare.gov. Accessed November 14, 2023. https://www.healthcare.gov/glossary/premium/
5. Deductible. HealthCare.gov. Accessed November 9, 2023. https://www.healthcare.gov/glossary/deductible/
6. Copayment. HealthCare.gov. Accessed November 14, 2023. https://www.healthcare.gov/glossary/co-payment/
7. Coinsurance. HealthCare.gov. Accessed November 14, 2023. https://www.healthcare.gov/glossary/co-insurance/
8. McCain J. Medical vs pharmacy benefit: the importance of a thorough benefits investigation to help navigate medical vs pharmacy benefit. National Association of Medication Access & Patient Advocacy, Inc. Accessed November 14, 2023. https://namapa.org/medical-vs-pharmacy-benefit
9. Prior authorization. AMCP.org. Published April 2012. Accessed November 14, 2023. https://www.amcp.org/Resource-Center/prior-authorization
10. Medicare & you 2024. Medicare.gov. Accessed November 14, 2023. https://www.medicare.gov/media/10991
11. Explanation of benefits. Glossary. Healthinsurance.org. Accessed November 14, 2023. https://www.healthinsurance.org/glossary/explanation-of-benefits/
12. Cancellations and appeals. U.S. Department of Health and Human Services. Last reviewed March 17, 2022. Accessed November 14, 2023. https://www.hhs.gov/healthcare/about-the-aca/cancellations-and-appeals/index.html
13. Appeal. HealthCare.gov. Accessed November 14, 2023. https://www.healthcare.gov/glossary/appeal/
14. Beneficiary. Cigna. Accessed November 14, 2023. https://www.cigna.com/glossary#beneficiary
15. Benefits. Centers for Medicare & Medicaid Services. Last modified May 14, 2006. Accessed November 14, 2023. https://www.cms.gov/glossary?term=benefits&items_per_page=10&viewmode=grid
16. Care plan. Centers for Medicare & Medicaid Services. Accessed November 14, 2023. https://www.cms.gov/glossary?term=care+plan&items_per_page=10&viewmode=grid
17. Centers for Medicare and Medicaid Services. USAGov. Accessed November 14, 2023. www.usa.gov/agencies/centers-for-medicare-and-medicaid-services
18. Claim. Centers for Medicare & Medicaid Services. Last modified May 14, 2006. Accessed November 14, 2023. https://www.cms.gov/glossary?term=claim&items_per_page=10&viewmode=grid
19. Coverage gap. Managed care glossary. Academy of Managed Care Pharmacy. Accessed November 14, 2023. https://www.amcp.org/about/managed-care-pharmacy-101/managed-care-glossary#
20. Understanding drug tiers. Patient Advocate Foundation. Accessed November 14, 2023. https://www.patientadvocate.org/explore-our-resources/understanding-health-insurance/understanding-drug-tiers/
21. CMS guidance: reporting expectations for dual-eligible beneficiaries, updated. Medicaid.gov. 2024. Accessed March 11, 2024. https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/51064
22. Eligibility. Centers for Medicare & Medicaid Services. Accessed November 14, 2023. https://www.cms.gov/glossary?term=Eligibility&items_per_page=10&viewmode=grid
23. Managed Care. healthinsurance.org. Accessed November 14, 2023. https://www.healthinsurance.org/glossary/managed-care/
24. What's the difference between Medicare and Medicaid? U.S. Department of Health and Human Services. Last reviewed December 8, 2022. Accessed March 11, 2024. https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html
25. What's Medicare Supplement Insurance (Medigap)?. Medicare.gov. Accessed November 15, 2023. https://www.medicare.gov/health-drug-plans/medigap
26. Network. HealthCare.gov. Accessed November 16, 2023. https://www.healthcare.gov/glossary/network/
27. Out-of-pocket. Centers for Medicare & Medicaid Services. Accessed November 14, 2023. https://www.cms.gov/glossary?term=Out-of-pocket&items_per_page=10&viewmode=grid
28. Payer. Centers for Medicare & Medicaid Services. Accessed November 14, 2023. https://www.cms.gov/glossary?term=payer&items_per_page=10&viewmode=grid
29. Preferred provider organization. Centers for Medicare & Medicaid Services. Accessed November 14, 2023. https://www.cms.gov/glossary?term=ppo&items_per_page=10&viewmode=grid
30. Prior authorization. HealthCare.gov. Accessed May 17, 2023. https://www.healthcare.gov/glossary/prior-authorization/
31. Referral. Centers for Medicare & Medicaid Services. Accessed November 14, 2023. https://www.cms.gov/glossary?term=referral&items_per_page=10&viewmode=grid
32. NASP definitions of specialty pharmacy and specialty medications. National Association of Specialty Pharmacies. Published February 24, 2016. Accessed November 14, 2023. https://naspnet.org/wp-content/uploads/2017/02/NASP-Defintions-final-2.16.pdf
33. Tricare. Centers for Medicare & Medicaid Services. Accessed November 14, 2023. https://www.cms.gov/glossary?term=tricare&items_per_page=10&viewmode=grid

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