vyepti®
(eptinezumab-jjmr)
100 mg/mL Injection for IV

Insurance Terms You May Find Helpful

Insurance is important, but it can get pretty confusing. Use this resource as a helpful guide to break down the key terms you may see or hear when discussing your plan with your provider.

Click on the insurance category you're interested in to find relevant terms for that plan.

Jump down to: General insurance terms | Commercial insurance terms | Medicare terms | Medicaid terms | TRICARE/VA terms

General insurance terms:

Here you'll find a collection of terms that apply to any insurance type, not just one in particular.

Administrative costs: The other functions of the healthcare system, aside from direct patient care—including medical billing, scheduling patient appointments, hiring and managing staff, and investing in quality improvement efforts.

Appeal: If you were denied coverage for a prescription drug, you have the right to ask your health plan to reconsider the decision by filing an appeal. Insurers have to tell you why they've denied your claim.

Annual enrollment period or open enrollment period: The period of time in which people can change their plans and prescription drug coverage for the following year to better meet their needs. For example, the period for Medicare is October 15th to December 7th.

Benefit verification: The process of verifying your active medical coverage with the insurance company and preventing billing issues.

Coinsurance: The percentage of the cost of a covered healthcare service you pay (20%, for example), often after you've paid your deductible. You are responsible for the coinsurance until you have met your maximum out-of-pocket (MOOP) cost for the plan year.

Copay: The fixed amount you pay for a covered health care service, often after you've paid your deductible. For example, you might pay $20 for a doctor's visit or prescription.

CPT (Current Procedural Terminology) code: A 5-digit numbering system that helps standardize professional and outpatient facility billing. There is a CPT code for certain types of medical services.

Deductible: The amount you pay for covered healthcare services each plan year before your insurance plan kicks in. After you meet the deductible, you'll only need to pay the copay amount or coinsurance depending on your plan design.

Explanation of Benefits (EOB): A statement sent to you by your insurance after they process a claim sent to them by a provider. The EOB lists the amount billed for medical treatments and/or services received, the allowed charges, the amount paid to the provider, and any copay, deductibles, or coinsurance due from you. The EOB may detail the medical benefits activity of an individual or family.

Formulary: A list of generic and brand-name prescription medicines covered by your plan.

Government-Sponsored Health Insurance: This type of health insurance is paid for and run by a federal or state agency. There are a few different types of government-sponsored health insurance, which have their own sets of eligibility requirements, such as age, income, disability, or military status. Examples include: Medicare, Medicaid, TRICARE, etc.

Healthcare common procedure coding system (HCPCS): A five-digit numbering system that helps healthcare providers and insurance companies communicate and track billing more efficiently.

Letter of Medical Exception: A letter written by your doctor explaining the medical reason why your plan should cover a drug that is not on its drug list or waive a coverage rule.

Letter of Medical Necessity: A letter written by your doctor verifying health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms.

Insurance Terms You May Find Helpful (Continued)

Life events (Special Enrollment Period): Certain events might allow you to make changes to your insurance plans. Some qualifying life events include losing your current health insurance coverage, getting married, or having a baby. Rules about when you can make changes and the types of changes you can make are different for each situation.

Maximum out-of-pocket (MOOP): The maximum amount of out-of-pocket cost you can expect to pay for medical expenses during any given plan year. Like the deductible, this amount resets at the start of each plan year.

Non-preferred provider: A provider who doesn't have a contract with your health insurance; this is often referred to as an out-of-network provider. You'll typically pay more to see a non-preferred provider than to see a preferred provider.

Out-of-pocket (OOP) costs: The portion of your covered healthcare or prescription drug costs which you are responsible for paying until you've met the maximum out-of-pocket amount for your plan.

Outpatient services: These are medical procedures or tests that can be done in a medical center without requiring you to stay overnight.

Predetermination of benefits: A review by your insurance plans medical staff to decide if they agree that the treatment is right for your health needs. Predeterminations are done before you get care, so that you will know early if it is covered by your health insurance plan.

Preferred Provider: A provider, often considered an in-network provider, who has a contract with your health insurer or a plan to provide services to you at a discount.

Premium: The payment you make to your health insurance company that keeps your coverage active – usually paid on a monthly basis.

Prior Authorization/Prior Approval/Precertification: Before agreeing to cover your procedure, service, or medication, your plan asks your doctor to provide information showing if the medication is medically necessary and appropriate for your situation.

Procedural costs: The costs associated with a specific procedure or service, which can include healthcare provider administration of a medication.

Specialty Pharmacy: A pharmacy focusing on specialty medicines for people with complex diseases. They are designed to efficiently deliver medications with special handling, storage, and distribution requirements. Unlike most medications you're probably used to, medicines from specialty pharmacies will be mailed to you or your healthcare provider (HCP).*
*Note: If a specialty pharmacy is used, VYEPTI will be shipped directly to your HCP or to your infusion location.

Step therapy: You may be required to try other medicines or take a few more "steps" before your plan will agree to cover your prescription for the specific medicine your doctor has prescribed.

Commercial Insurance terms:

Commercial insurance, also known as private insurance, is coverage that's sold directly to you or to your employer. Types of commercial insurance plans include a Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO), an Exclusive Provider Organization (EPO), a Point of Service (POS) plan, or a Fee-for-Service (FFS) plan.

Here are some terms you might come across if you have commercial insurance:

Flexible Spending Account (FSA): A special account you put pre-tax money into that you can use to pay for certain out-of-pocket healthcare costs, such as copays, deductibles, and some medications. Money in this account must be used before the end of the year.

Health Savings Account (HSA): A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses such as deductibles, copays, or coinsurance. There is no time limit (or "expiration") for using your HSA funds. HSAs may only be available if you have certain plan types.

Health Insurance Marketplace (or Exchange): A shopping and enrollment service for medical insurance created by the Affordable Care Act in 2010.

Insurance Terms You May Find Helpful (Continued)

Medicare terms:

Medicare is a federal health insurance program for people aged 65 years and older, and/or people with certain disabilities.

You've probably heard of or seen Medicare followed by different letters. That's because there are four different types of Medicare plans that cover different patient costs. They include:

Part A - Hospital Insurance: Helps pay for inpatient hospital stays, skilled nursing facility care, hospice care, and home health care.

Part B - Medical Insurance: Helps cover medically necessary doctor visits, diagnostic testing, and other preventive care; also covers some medications that need to be given in the doctor's office, such as an infusion.†
†Note: This is the type of Medicare coverage that may cover VYEPTI.

Part C - Medicare Advantage (MA): Combines Part A and Part B, and sometimes Part D, and is offered by a health plan company that is approved by Medicare; MA plans that include prescription drug coverage are sometimes called "MA-PDs."

Part D - Medicare Prescription Drug Coverage: Helps you pay for prescription drugs that are considered medically necessary; these drugs are usually self-administered (taken outside of the HCP office).

Here are some common terms you might come across if you have Medicare:

Dual-Eligible: A beneficiary who is eligible for both Medicare and Medicaid.

Medicare Extra Help (also known as the Low-Income Subsidy or LIS): A Medicare program that helps people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Service area: The geographic area where a health insurance plan accepts members.

Medicaid terms:

Medicaid is a joint federal and state program, separate from Medicare, that helps pay medical costs for people with low incomes, limited assets, and disabilities.

Here is a term you might see:

Care Coordination: How interdisciplinary healthcare professionals work with patients to ensure that their health needs are being met and that the right provider is delivering the right care at the right time. The concept typically applies to Medicaid managed care and Medicaid health homes.

TRICARE/VA terms:

TRICARE or the Veterans Administration healthcare program are government healthcare programs for service members, retirees, their families, and others registered in the Defense Enrollment Eligibility Reporting System (DEERS).

TRICARE offers several different health plans. Plan availability depends on your status in the military and where you live. Your benefits and plans will vary depending on your beneficiary category.

Types of Beneficiaries
Sponsors—active duty, retired, and Guard/Reserve members.
Family members—spouses and children who are registered in DEERS.

For more information, please see the Prescribing Information and Patient Information.

The information provided herein is intended for residents of the US. This information is provided for educational purposes only and is not intended to replace discussions with a healthcare provider or health plan.