Health Insurance 101:
Understanding Your Options

Health insurance is complicated.

- This guide breaks down what you need to know about health insurance and provides resources to help you understand your options
- Eligibility for insurance plans varies. You may not be eligible for every insurance plan discussed in this guide

This resource will guide you through:

Contact your myAgios® Patient Support Manager to learn more about these topics

Throughout this guide, you will come across key terms **underlined in blue**. These words are defined in the glossary beginning on page 10.

Please note that myAgios® Patient Support Services cannot recommend individual insurance plans. However, our Patient Support Manager will guide you every step of the way—from enrollment forms to insurance questions and challenges.

Types of Health Insurance

There are 2 types of health insurance: commercial and government-subsidized.

Review the charts below for more information to find the plan that may best suit you.

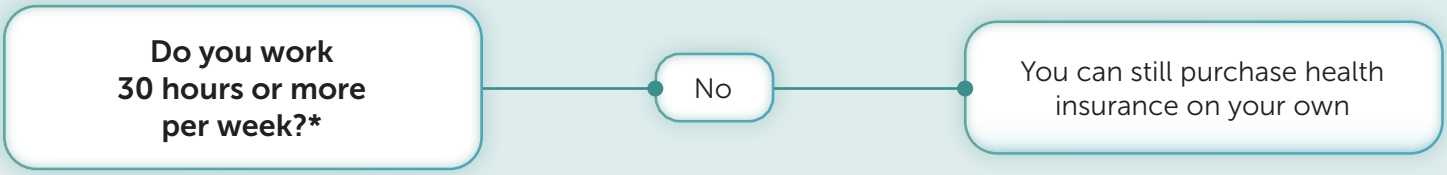
Commercial Insurance:
Group Plans & Individual Plans

Commercial health insurance is a type of health insurance plan often offered by an employer to provide benefits to its employees and can also be purchased by individuals or families on their own.

There are different types of plans available through commercial insurance coverage, such as HMO, PPO, and HDHP. For more details, please contact your myAgios® Patient Support Manager.

Group Plans

Insurance coverage is offered through an employer. Usually, the employee and the employer both contribute to the premium.



Individual Plans

Health insurance is purchased by individuals or families on their own directly from a private insurer (non-government), or through the Health Insurance Marketplace (also known as the Health Insurance Exchange).

- Visit the Health Insurance Marketplace at **HealthCare.gov** or contact your state-based Marketplace
- Before purchasing an individual plan, check to see if you qualify for Medicare or Medicaid **(see pages 3-4 for more information)**

*You may also be eligible for commercial insurance through the job of your spouse or domestic partner.

Agios offers myAgios® Patient Support Services for patients taking Agios medications and their caregivers. It is not an insurance program. For more information, go to page 9 and/or call a Patient Support Manager to learn more at **1-800-951-3889**, Mon-Fri, 8 AM to 6 PM, ET.

Government-Subsidized Insurance

Do you work 30 hours or more per week?*

→ No → Do you have low income?

→ Yes → You may qualify for Medicare or Medicaid

Medicare, Medicaid, and TRICARE®

People who are eligible for government-subsidized health insurance have their health care expenses partly or completely paid for by the government. Medicare and Medicaid are 2 of the major types of government insurance.

Medicare

! If you are age 65 or older, or disabled, Medicare may be an option for you.

Medicare is a government-funded health insurance program for people aged 65 or older, younger people with certain disabilities, those with end-stage kidney disease (requiring dialysis or kidney transplant), or people diagnosed with ALS (also known as Lou Gehrig's disease).

For those eligible, enrolling in Medicare includes Parts A and B. Medicare also offers the choice of 1 or more options:

Part C: Medicare Advantage

Combines hospital insurance, medical insurance, and usually drug coverage.

Also can include additional benefits, such as dental and vision coverage as well

Part D: Drug Coverage

Helps cover the cost of prescription drugs.

Also known as Medicare Prescription Drug Plan (PDP)

Part D: Extra Help

Helps people with limited income and resources lower or cut Part D costs, including deductibles and copays.

To apply for the Extra Help Program, click **here**

*You may also be eligible for commercial insurance through the job of your spouse or domestic partner.
ALS, amyotrophic lateral sclerosis.

myAgios® is here to support you in your unique journey. Get your insurance questions answered by calling our Patient Support Manager at **1-800-951-3889**, Mon-Fri, 8 AM to 6 PM, ET.

Government-Subsidized Insurance:
Medicare, Medicaid, and TRICARE® (continued)

Medicaid

! Medicaid provides health coverage to individuals with low income and individuals in other categories.

Medicaid is a joint federal and state program that provides health coverage to low-income individuals, children, pregnant women, elderly people, and people with disabilities.

Medicaid covers:

- Inpatient and outpatient hospital services, doctor visits, prescription drugs, lab and X-ray services, and other items

Each state can have different eligibility criteria for Medicaid.

Dual eligibility

! Some people can qualify for both Medicare and Medicaid at the same time.

People who are dual-eligible can receive both Medicare and Medicaid benefits at the same time. Dual-eligible individuals tend to have more medical needs and/or lower income, compared to others.

Some benefits include:

- For drug costs, you will be automatically enrolled in a Medicare drug plan that will cover your drug costs instead of Medicaid, meaning you will never pay 100% of the cost for drugs covered by Medicare
- For medical and hospitalization costs, Medicare will be primary coverage and Medicaid will pick up any remaining balances on covered services
- Medicaid may also cover long-term care services at home or in your community

Contact your Patient Support Manager for more information about dual eligibility.

TRICARE®

This health insurance plan is for members of the military, their spouses, children, and survivors; military retirees are also eligible. Many veterans receive their health care through the Veteran's Health Administration (VHA), which is the health care system that services military veterans.

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Choosing an Insurance Plan

Choosing an insurance plan can be complicated, and there are many things to consider to make the best choice for you and your family.

Things to know:

Pharmacy Benefit Managers (PBMs)

PBMs are third-party companies that act as intermediaries between community pharmacies, insurance companies, and pharmaceutical manufacturers. They provide access to prescription medication while keeping costs at a minimum through formulary management, set copay tiers, process drug claims, and negotiate contracts between insurers and manufacturers.

Examine coverage details

Every health insurance plan has different health and prescription drug benefits and coverage. Before enrolling in a new plan, be sure to call the insurance company and have a representative go over your medications, doctors, and specialists, and review the details of how they will be covered. **Contact your myAgios® Patient Support Manager for help preparing questions to ask.**

Example questions to ask when you call each insurance plan:

- "Are my medications on the formulary?"
- "Are the doctors and specialists I currently see, or plan on seeing, in-network, and will I need a referral?"

Determine out-of-pocket expenses

For each insurance plan you are considering, you will want to find out the total costs. You may have to pay a deductible, premiums, and expenses like a co-pay or coinsurance until you reach the out-of-pocket maximum.

If your insurance policy changes, please be sure to contact your Patient Support Manager. Your Patient Support Manager is also available to discuss financial assistance options. Get your questions answered by calling your Patient Support Manager at **1-800-951-3889**, Mon-Fri, 8 AM to 6 PM, ET.

See page 6 for the Comparing Plans worksheet to help you decide between insurance plans.

Comparing Insurance Plans

When you're comparing health insurance plans, you may use this worksheet to help you decide between plans.

Insurance Plan A		Insurance Plan B	

PLAN INFORMATION	PLAN A ($ per month)		PLAN B ($ per month)	
Premium -Individual				
Premium -Family or Individual +1				
Annual cost	In-network ($ per year)	Out-of-network ($ per year)	In-network ($ per year)	Out-of-network ($ per year)
Deductible -Individual				
Deductible -Family or Individual +1				
Out-of-pocket maximum -Individual				
Out-of-pocket maximum -Family or Individual +1				

MY CURRENT HEALTHCARE PROVIDERS		PLAN A		PLAN B	
Healthcare provider	Name of doctor	Covered (Y/N)	Co-pay/co-insurance ($ or % per visit)	Covered (Y/N)	Co-pay/co-insurance ($ or % per visit)
Primary care					
Hematologist					

MY PRESCRIPTIONS	PBM	PRESCRIPTION DRUG PLAN A			PRESCRIPTION DRUG PLAN B		
Medicine name	PBM	Covered (Y/N)	Co-pay/co-insurance ($ or % per fill)	PA required (Y/N)	Covered (Y/N)	Co-pay/co-insurance ($ or % per fill)	PA required (Y/N)

Please note that a myAgios® Patient Support Manager cannot investigate individual plan details for you. If you have questions about individual insurance plans or need help filling out this worksheet, please reach out to the health plan provider. myAgios® will guide and support you every step of the way—from enrollment forms to insurance questions and challenges.

PA, prior authorization; PBM, pharmacy benefits manager.

Updating Your Insurance Policy

What to do after you change your plan:

- [ ] **Get familiar with your new insurance card.** You will need to give the new information to your entire care team once your plan has changed. They may need your:
  - **Member ID number** – This number is just for you and identifies you as a covered member. You need your member ID number to access benefits
  - **Group number** – Depending on your plan, a group number could be listed on your card. This helps identify the benefits you receive. Your health care providers may need this number to file a claim for you
- [ ] **Update your health care team.** Once your insurance plan has changed, let your doctor and other members of your health care team know about the switch.
- [ ] **Update your Patient Support Manager.** By providing your latest insurance information, your Patient Support Manager will address any questions, provide helpful resources, and notify your provider. When your plan changes, call a Patient Support Manager at **1-800-951-3889**, Mon-Fri, 8 AM to 6 PM, ET.
- [ ] **Inform your pharmacy.** You should let your pharmacy know about your insurance change as soon as possible, so there are no delays in receiving your medications. You may have 2 separate insurance cards: one to use at a hospital or doctor's office and a second one to use at the pharmacy. A pharmacy benefit manager (PBM) administers your prescription drug benefit for your health insurance plan and will mail you the pharmacy insurance card.

! Open enrollment is one of the times when you can change your health insurance.

Loss of employer-based coverage

If you have recently left your job and/or otherwise lost your employer-based coverage, you may have the following options:

COBRA (Consolidated Omnibus Budget Reconciliation Act) – With COBRA, you have the option to continue the coverage you received with your previous employer for a limited amount of time.

Individual insurance – You can buy an individual insurance plan directly from a private insurer or through the Health Insurance Marketplace at **HealthCare.gov**.

Medicare and Medicaid – If you qualify for government-funded insurance, you can enroll in these programs at any time.

! If you're eligible for financial support, we can help you find programs for accessing your medication. Our Patient Support Managers will guide you every step of the way—from enrollment forms to insurance questions and challenges.

myAgios® is here to support you with changes in insurance coverage, loss of insurance, and other financial support in your unique journey. Get your insurance questions answered by calling our Patient Support Manager at **1-800-951-3889**, Mon-Fri, 8 AM to 6 PM, ET.

The Drug Coverage Process

Benefits investigation

After writing a prescription, your doctor's office may conduct a benefits investigation to determine the health insurance plan's benefit design and coverage requirements for the prescribed medication.

Request prior authorization (PA)/medical exception (ME)

A PA or ME are requests for coverage by the health plan made before treatment starts. Insurers will require a PA for some types of medications, especially those that have a high cost or are for complex health conditions. The doctor's office will complete the necessary paperwork.

- The health plan will review this information and either approve or deny the PA. They will contact you and/or the doctor's office with a decision
- If the health plan denies a PA or ME request, you have the option to appeal the decision. There may be 3 or more levels of appeal. See the bottom of this page for information on how to request an appeal

Receive treatment with the prescribed medication

If there is an approval and the prescription is covered, you receive the medication. Typically, approvals are good for 6 to 12 months, after which they would need to be re-authorized.

- If out-of-pocket costs for your medication are difficult to pay for, **talk to your Patient Support Manager to discuss financial assistance options**

How to Request an Appeal

You would only request an appeal if a PA/ME gets denied. Typically, there are 3 levels in the appeal process:

Level 1

- You or your doctor's office may contact the plan and request that it reconsider its denial decision
- Your doctor may ask to speak to a medical director, a doctor who works at the health plan, to resolve the denial

Level 2

- You or your doctor may request a second-level appeal if the initial appeal is denied
- A medical director who was not involved in the original decision usually reviews the second-level appeal

Level 3

- If the denial cannot be resolved with the health plan, you may have the right to request an independent third-party review
- This means the health plan will no longer have the final say regarding coverage and is required by law to accept the external reviewer's decision

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myAgios® Patient Support Services

A customized support program for patients and caregivers living with rare genetic diseases.

A Dedicated Patient Support Manager is here for you

What happens when you have a Patient Support Manager on your team?

You get personal support.

Your Patient Support Manager will get to know you and your story. You'll chat with them, and they'll listen to your concerns and understand what you're looking for. Then, they can provide you tools to help you understand your condition and access your prescribed treatment.

No matter where you are in your journey, our Patient Support Manager will act as your ally and help with all sorts of questions, including:

How do I get the support I need living with my condition?
Whether you're newly diagnosed or have been living with your condition for a while, a Patient Support Manager can give you educational materials on your condition, including what it is, its causes, how to get free genetic testing, and other helpful resources.

How do I get more details on my prescribed treatment?
A Patient Support Manager is available to answer questions and share tips on having discussions with your treatment team.

Can I get help accessing my treatment?
A Patient Support Manager can help you find support for accessing your treatment. They'll guide you every step of the way, including:

- Program enrollment to receive your prescription
- Navigating insurance questions and challenges
- Getting financial support if you're eligible

We're ready when you are. Get your questions answered by calling our Patient Support Manager at 1-800-951-3889, Mon-Fri, 8 AM to 6 PM, ET. When you are enrolled in myAgios, Patient Support Managers will act as your ally to provide tailored support, educational resources, and connections to the community. Enroll in the program today.

Learn more at Home.myAgios.com

The purpose of this program is NOT to offer medical or treatment-related advice.
For these types of questions, contact your doctor.

Glossary of Key Insurance Terms

Below are terms you may have come across in this guide. Contact your Patient Support Manager for further explanations of each term.

Appeal

A request for your health insurer or plan to review a coverage decision again.

Claim

A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.

Coinsurance

The percentage of the costs you are required to pay for a covered health care service or prescription medication after you've paid your deductible, if applicable.

Co-pay (co-payment)

The fixed dollar amount (eg, $15) you pay for a covered health care service, usually at the time you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your plan covers before your plan begins to pay.

For example, if your deductible is $1000, your plan won't pay anything until you've paid the $1000 deductible for health care services. The deductible may not apply to all services.

Extra Help

This Medicare program is designed to help people with limited income and resources pay for Part D costs.

Formulary

A list of preferred drugs chosen by your plan. Both brand and generic medications are included on the formulary.

Health Insurance Marketplace

The Marketplace provides coverage to people who don't have access to a group plan and who don't qualify for Medicare or Medicaid.

Health Maintenance Organization (HMO)

A type of health plan that provides health care coverage to its members through a preferred network of doctors, hospitals, and other health care providers.

High Deductible Health Plan (HDHP)

This is an insurance plan with a large deductible.

HDHP Coverage	Minimum Deductible	Maximum Out-of-Pocket Expense
Self only	$1400	$6900
Family	$2800	$13,800

In-Network

Services provided by a doctor or other health care provider with a contract with the insurance company that the insurance will pay a higher percentage for. These services will usually cost you less.

Glossary of Key Insurance Terms (continued)

Medicare Part A: Hospital Insurance

This covers hospital stays, home health care, and hospice care.

Medicare Part B: Medical Insurance

This covers services from doctors and other healthcare providers, durable medical equipment, and preventative services.

Medicare Part C: Medicare Advantage

This combines hospital insurance, medical insurance, and usually drug coverage and can include additional benefits, such as dental and vision coverage.

Medicare Part D: Drug Coverage

This helps cover the cost of prescription drugs and is also known as Medicare Prescription Drug Plan (PDP).

Open Enrollment

The period of time where you can enroll in a health plan, usually once a year. There may be other special periods when you may be able to sign up for new health insurance; talk to your health plan for more details.

Out-of-Network

Services are considered out-of-network when you use a doctor or other provider that does not have a contract with your health plan. Out-of-network services may not be covered; you may have to pay all or some of the bill.

Out-of-Pocket Maximum

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copays, and coinsurance, your health plan pays 100% of the costs of covered benefits.

Pharmacy Benefit Manager (PBM)

Third-party companies that create formularies, negotiate rebates with manufacturers, and process claims, among other things.

Preferred Provider Organization (PPO)

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to that plan's network.

Premium

The amount that must be paid for your health insurance plan. You and/or your employer usually pay it on a monthly, quarterly, or yearly basis.

Prior Authorization (PA)

The process by which you and your doctor get approval from the health plan, which can include prescription medications or diagnostic tests. Your plan will have certain requirements that they want you to meet before approving coverage for certain items.

For example, it could include your medical history, diagnosis, previous treatments, lab values, etc. Their goal is to make sure that the medication or test is medically appropriate for your condition, while considering if there are other lower cost treatments available.

Referral

Typically used for an HMO plan, this is a written authorization from a member's primary care physician (PCP) to receive care from a different contracted doctor, specialist, or facility.

Specialty Drug (Specialty Pharmacy)

A prescription used to treat complex health conditions. These drugs may require a specific treatment plan, have special handling or storage needs, and not be sold in retail pharmacies.

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