

Understanding Health Plans

General information about health insurance coverage and plan considerations

The information provided in this guide is of a general nature and is for informational purposes only; it is not intended to be comprehensive. Amgen is not an insurance specialist or licensed insurance broker and does not guarantee the accuracy of the information in this guide. All information should be independently verified.



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What to Think About When Choosing a Health Plan

People living with rare diseases often have healthcare needs that may require extra planning. You may need access to medical experts who are not close to home. Also, **specialty** medicines may require extra steps before you can begin treatment. This guide provides general information about insurance basics, coverage approval processes, and considerations when choosing a health plan.

Definitions for **bold terms** throughout may be viewed in the glossary on pages 14-15.

Understanding your health plan can help you make informed decisions and ask questions about your care. Knowing what to look for in a health plan is a good starting point. Use the Table of Contents to explore topics that may help inform your health plan decisions, and ask your care team questions when something is unclear.

What are some things to consider when reviewing a health plan?

Doctors and specialists

Medicines and treatments

Costs



- It may be helpful to see if your specialist is **in-network**
- Consider asking your doctor or health plan if you will need a **referral** to see a specialist or to get certain services
- You may want to check if your health plan covers care outside your home state
 - Sometimes people with rare diseases are referred to a specialty center outside their state for treatment

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- It's important to check if your medicine is on the health plan's **formulary**
 - You can typically find the formulary listed on the plan's website or by calling the plan's customer service
 - Infused medicines are typically covered by the health plan's medical benefit policies
- Consider asking your health plan or doctor if you will need **prior authorization (PA)** to cover certain care or medicines
 - A PA is usually required by insurance. Your doctor completes the PA based on health plan requests
 - For example, your health plan may request medical records/test results before approving coverage
- You might find it helpful to review **specialty** pharmacy requirements
 - Some specialized medicines must be filled through a specific pharmacy
 - Check with your health plan to see if they require use of a specialty pharmacy. If so, ask which one(s)

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- You may want to review the **Summary of Benefits (SOB)** to understand what your health plan covers and how you and your health plan share costs
 - Comparing **premiums** and **deductibles** can help you to understand what you may pay for your medicines and treatments
- It's helpful to know your **out-of-pocket (OOP) maximum**
 - This is generally the most you will pay in a plan year for covered care
 - After you reach this amount, your health plan generally pays 100% of eligible covered costs for the remainder of the plan year
- Consider checking coverage and costs for specialty medicines and/or **infusions**
 - Medicines taken at home are often covered under pharmacy benefits. Infusions given in a clinic, hospital, or at home may be covered under medical benefits

Rare Disease Health Plan Checklist

Consider this list as you explore your options

When you have a rare disease, there may be extra things to consider when choosing a health plan.

This checklist may be helpful when reviewing health plan options. (For information on financial assistance, see page 6)



Care:

- Is my doctor/specialist **in-network**?
- Do I need **prior authorization**?
- Do I need **referrals** for **specialty** care?
- If I change health plans, will my current treatment need new approval?



Medicine:

- Is my treatment center in-network?
- Is my medicine on the **formulary**?
- Are home infusions covered, if I need them?



Costs:

- What are my **out-of-pocket costs** each year?
- Is out-of-state care covered? If so, when (emergency vs regular care)?
- Which specialty pharmacies can I use?

Being prepared can help

Consider:

- Making a list of your current medicines
- Writing down your specialists and treatment center
- Keeping your insurance ID card handy
- Saving your health plan's customer service number
- Knowing who to contact if you have questions, such as your health plan or doctor

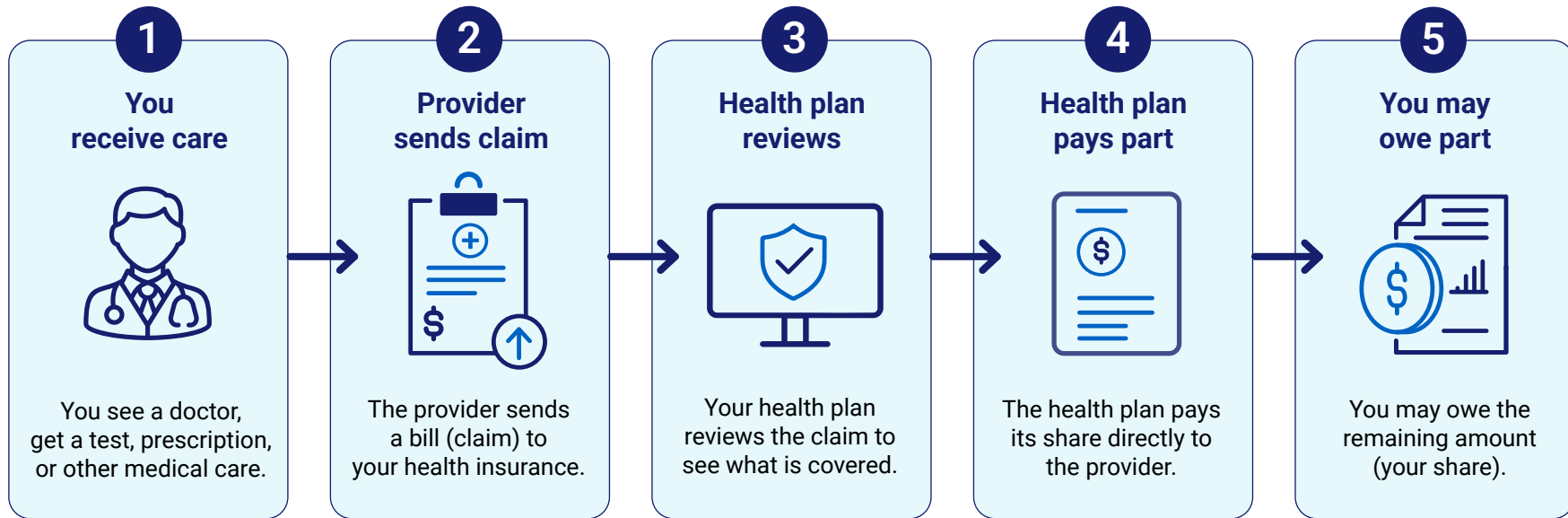


If your specialist is out of network:

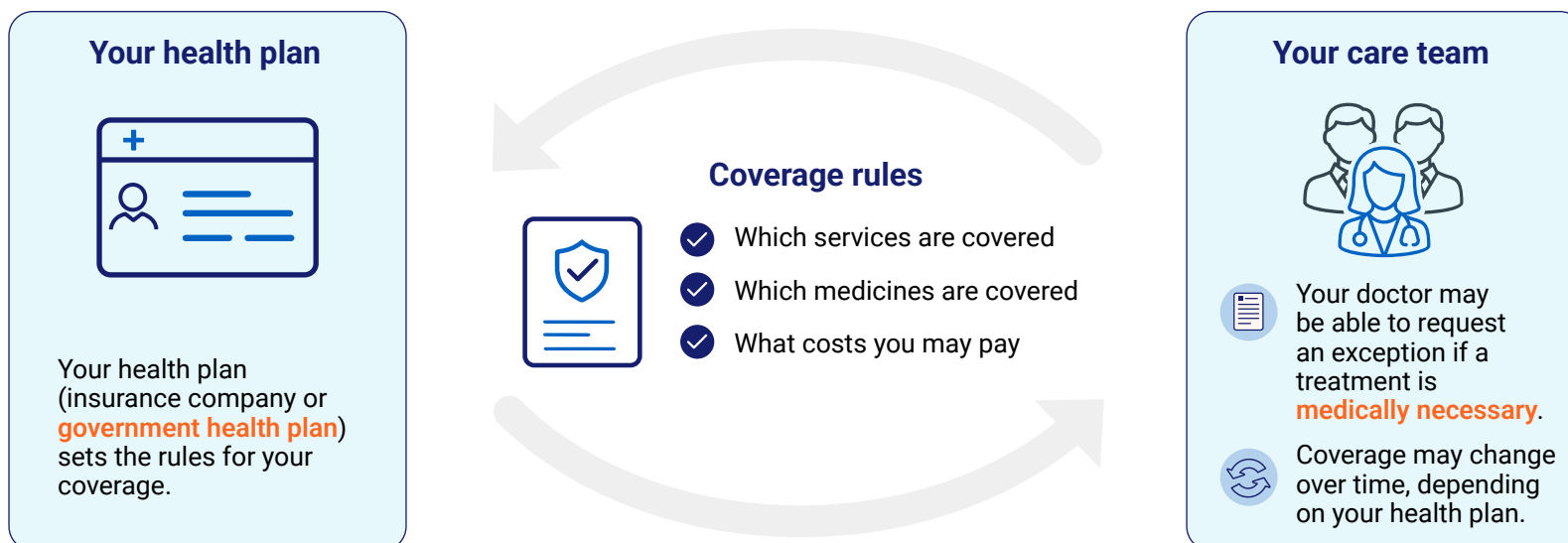
- You may have to pay more for care, or the health plan may not cover the visit at all
 - Financial assistance may be available to help cover out-of-pocket costs
- Some plans may approve exceptions if you need specialized care that is not available in-network

Insurance Basics

How health insurance works: step by step



Who decides what's covered?



Insurance Basics (cont'd)

What you pay

Common out-of-pocket costs



Deductible

The amount you must pay for care before your health plan starts to pay. This amount is determined by your health plan.

Example

You have a \$1,000 **deductible**. You pay the first \$1,000 of covered services yourself.



Co-pay

A fixed amount you pay for a covered service, like a doctor visit.

Example

You pay a \$25 co-pay for a primary care visit.



Co-insurance

Your share of the cost of a covered service, after you meet your deductible.

Example

Health plan pays 80% and you pay 20% of the cost.



Out-of-pocket maximum

The most you generally pay in a plan year for covered **in-network** services. After you reach this amount, your health plan generally pays 100% of eligible covered in-network costs for the remainder of the plan year.

Example

Your **out-of-pocket maximum** is \$6,000. After you reach this amount, your health plan generally pays 100% of eligible covered in-network costs for the remainder of the plan year.

**TIP**

Where to find financial support

Financial assistance may be available to help with the cost of treatment or care. Some sources of support are:

- Independent nonprofit foundations
- Disease-specific advocacy organizations
- Government programs or other community resources

Financial assistance programs have their own eligibility requirements and may not be available to everyone.

Costs and coverage can vary by health plan. Check your health plan documents or call your health plan for details.

Understanding your Explanation of Benefits

Getting Coverage for Care and Medicine

Knowing your plan's network

It can help to check whether your doctors, specialists, hospitals, and treatment centers are in your health plan's **network**. If you see doctors or use facilities that are out of network, you may have to pay more. If you have **Medicaid**, you may only be able to see providers in your state who accept Medicaid. If you are enrolled in a **Medicaid managed care plan**, you may also need to use providers in that plan's network.



TIP

Can you use Medicaid as a secondary insurance?

- In some cases, yes. Medicaid may help pay for costs not covered by your primary health plan
- For more information about Medicaid, go to the Medicaid website at [MEDICAID.gov](https://www.MEDICAID.gov)

Depending on your situation, you may need to travel to another state for care. Health plans generally cover emergency care out of state. But coverage for other out-of-state services may be limited. Some plans may make exceptions. An example is if you live near a state border and commonly receive care in another state. You may want to review these rules before choosing a health plan.

Getting Coverage for Care and Medicine (cont'd)

How different kinds of medicine are covered

Formularies for **commercial** and **government health plans** may include both brand-name and generic drugs. It's a good idea to consider checking if your medicine is on the health plan's formulary before choosing a health plan.

If your medicine is not listed on the **formulary**, there may be a process to request coverage if your doctor provides information showing that it is needed for your condition or that it is **medically necessary**.

Coverage considerations for specialty medicines

Because **specialty** medicines can be complex, they may have different rules, costs, or steps for coverage.

For example, some health plans may require you to try certain medicines first before they will cover the specialty medicine. This is called **step therapy**.

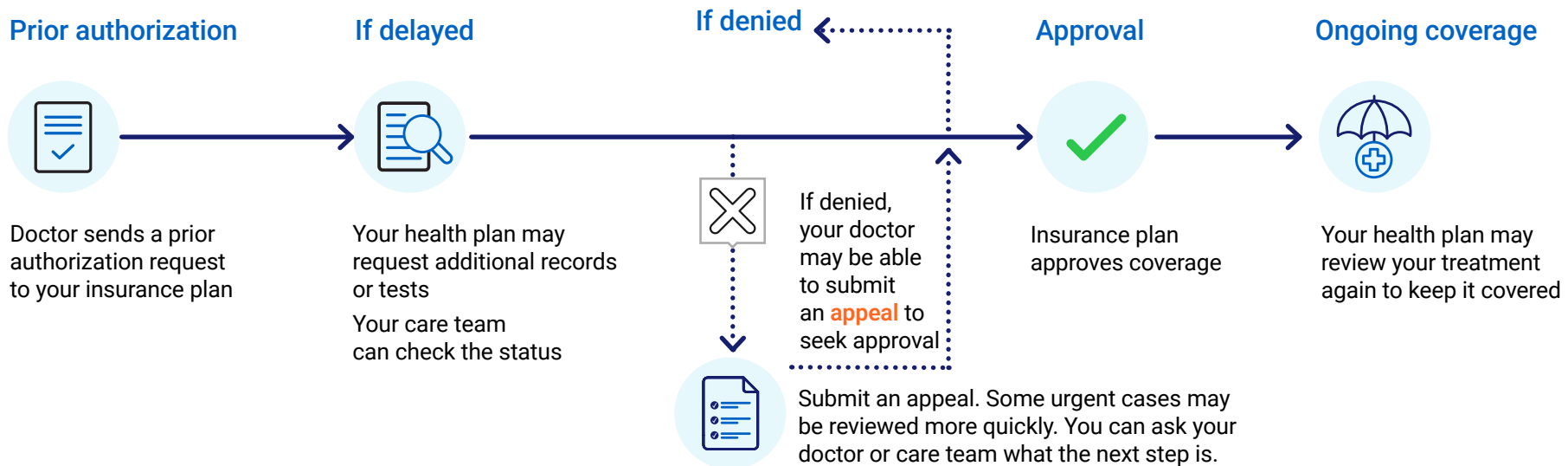
Specialty medicine coverage

Medicine type	Where you receive it	Usually covered by
 Pill/liquid	At home	Pharmacy benefit
 Injection	At home/at clinic	Pharmacy benefit/medical benefit
 IV infusion	At home/infusion center/hospital	Medical benefit

Getting Coverage for Care and Medicine (cont'd)

How does the insurance approval process work

If **prior authorization** is required, your doctor may submit a request to your health plan. This request may include medical records such as lab results related to your diagnosis. The health plan reviews the request to determine whether the medicine is covered. The health plan may ask for more information, which can take time. The graphic below provides a general example of the approval process; specific requirements and steps vary by health plan.



What may be needed before your medicine is approved for coverage

Your health plan may require:



Your doctor prescribes a medicine



Your health plan[†] covers or reviews the request. (Your health plan may require: prior authorization, **step therapy**, or **reauthorization**)



Once your health plan makes a coverage decision, you can consider next steps in your care

[†]**NOTE:** A separate company (pharmacy benefit manager or PBM) is sometimes involved to manage your prescription drug coverage.

Comparing Health Plan Types

Health plan type: private or commercial

A **private health plan** or **commercial insurance** is offered by a private company. It can include coverage through an employer, the **Marketplace**, a spouse, another family member, or labor union. You can also buy a health plan directly from an insurance company. The health plan's policy outlines what is covered.

- Open enrollment is typically a set time each year when you can sign up for or change your health plan. Formularies, **networks**, and coverage rules can change every year. Consider reviewing coverage during open enrollment to see if anything changed
- A **qualifying life event** is a special situation that lets you sign up for health insurance outside of the open enrollment period (for example, losing your current health insurance, changes in your household, or change of address)

See the table below for common private health plans and how they differ. If you have questions about whether a health plan may meet your needs, consider contacting the plan before enrolling to ask about your specialist, treatment center, and medicine.

Key features of different health plans



Health Maintenance Organization (HMO)

- **In-network** only
- No out-of-network coverage (except emergencies)
- Referrals to see a specialist are usually needed

Things to consider: May work well if you are comfortable using a smaller network and referrals



Preferred Provider Organization (PPO)

- Larger network
- Out-of-network coverage
- No referrals to see a specialist are needed

Things to consider: May offer more flexibility if you see multiple specialists or need out-of-network care



Exclusive Provider Organization (EPO)

- In-network only
- No out-of-network coverage (except emergencies)
- No referrals to see a specialist are needed, generally

Things to consider: May work well if your needed specialists are already in the network

(continued on next page)

Any of the health plans above may also have tiered provider networks. "Tiered" means health plans rank the doctors and hospitals by quality and cost, with those with the highest quality and lowest cost are placed in the preferred level, or tier. When you go to see a doctor, you may pay less when you choose a network provider in a preferred tier.

Generally, plans with smaller provider networks and more limited choices may have lower premiums. But other factors also contribute to your costs. This includes **deductibles** and how much you may pay for treatment that's not covered.

Comparing Health Plan Types (cont'd)

Health plan type: private or commercial (cont'd)

Key features of different health plans



Point of Service (POS)

- Network + out-of-network coverage
- Referrals usually needed
- Lower costs in-network

Things to consider: May give you some flexibility with lower costs in-network



High-Deductible Health Plan (HDHP)

- Can be any one of the following: HMO, PPO, EPO, or POS
- Higher deductible
- Out-of-network coverage depends on plan type

Things to consider: May work if you want lower premiums and can plan for higher costs



Fee for Service (FFS)

- Out-of-network coverage available
- No referrals needed
- You pay provider directly and file for reimbursement

Things to consider: May offer maximum flexibility



TIP

What information should you keep about your health plan?

Consider keeping copies of your insurance ID cards, coverage letters, **appeal** documents, **EOBs**, and notes from phone calls with your health plan

Comparing Health Plan Types (cont'd)

Health plan type: government

Government health plans are plans funded by the state and/or federal government and include the following:

Government-funded health plan	Who is covered
Medicaid	• People with family incomes below a set limit* • People with serious or extensive health needs, sometimes called “medically needy.” This includes those whose income is too high to otherwise qualify • People with disabilities
Medicare	• People aged 65 years and older • Certain people younger than age 65 years with disabilities • People with end-stage kidney disease
Children’s Health Insurance Program (CHIP)	• Children in families whose income is above the limit for Medicaid* • Pregnant women (some states)
TRICARE (US Department of Defense)	• Active military members and their families • Active National Guard or Reserve members and their families • Surviving family of military, National Guard, or Reserve members • Some former spouses of military, National Guard, or Reserve members • Medal of Honor recipients and their families
Veteran’s Administration (VA) Healthcare	• Former military, National Guard, or Reserve members

*Visit your state’s Medicaid website to find the income limits.

Some doctors’ offices will not accept Medicaid or CHIP coverage. If you or your child is covered through one of these programs, consider checking with the office staff before making an appointment. If they do not accept coverage, you may want to contact your state Medicaid or CHIP agency.

Support for people with disabilities 

Getting Answers From Your Health Plan

This guide has provided general information about health plans and the coverage process. You may wish to contact your health plan or care team with questions about your specific circumstances.

Consider the following when contacting your health plan:

- Ask for an explanation if something isn't clear
- Write down the name of the person you spoke with and the date
- Request important decisions in writing
- If coverage is denied, ask what the next step is and whether an **appeal** is available
- Reach out to your doctor or care team if you need help navigating the process



Glossary

The glossary below provides general definitions of the **bolded terms** used throughout this guide.

Appeal—a request to your health plan to review a decision denying coverage or payment.

Commercial health plan—health insurance policy offered by a private company; same as “private health plan.”

Compassionate allowance—label given to a disease or condition that by definition meets the Social Security Administration’s standards for disability benefits. The label is intended to permit quick identification of these diseases or conditions.

Deductible—the amount you pay for covered medical services before your health plan starts to pay.

Explanation of Benefits (EOB)—after you receive medical services or fill a prescription, a summary from your health plan of information such as what services it covered.

Formulary—a list of medicines covered by a health plan or prescription drug plan.

Government health plan—health plans, like Medicare and Medicaid, that are funded by the state and/or federal governments.

In-network—refers to use of a doctor or other healthcare provider who has a contract with the health plan to provide patients with services at set rates.

Marketplace—often a website where you can compare and choose health plans; also available by phone and in-person.

Medicaid—state and federal government-funded health plan primarily for people who earn below a set income limit and people with disabilities.

Medicaid managed care plan—Medicaid health plans, funded by the government, that are managed through contracts with private managed care companies.

Medically necessary—medicines, medical supplies, and services that are needed to diagnose and/or treat an illness or condition.

Medicare—a federal health insurance program managed by the Centers for Medicare & Medicaid Services. It provides coverage for people aged 65 years and older, certain people with disabilities, and people of any age with diagnosed end-stage renal disease (ESRD).

Network—a group of healthcare providers and suppliers who have contracted with a health plan to provide services at certain rates.

Out-of-pocket costs—all the expenses for medical care not paid by your health plan, which you are responsible for paying. These include co-insurance, co-payments, deductibles, and expenses for services that are not covered. Many health plans have an out-of-pocket maximum to limit yearly costs to the patient.

Out-of-pocket maximum—this is generally the most you will pay in a plan year for covered care. After you reach this limit through deductibles, co-pays, and co-insurance, your health plan generally pays 100% of eligible covered costs for the remainder of the plan year.

Premium—the amount you pay for your health plan, usually every month (may be quarterly or yearly).

Prior authorization (PA)—a process your doctor may need to complete to explain why you need a medicine, treatment, or service and why your health plan should cover it.

Private health plan—health insurance policy offered by a private company; same as “commercial health plan.”

Glossary (cont'd)

Qualifying life event—special circumstances that allow you to sign up for health insurance outside of the open enrollment period. These include loss of your current health insurance, changes in your household, and a change of address (ZIP code or county).

Reauthorization—the renewal of the prior authorization after a certain period of time. Health plans may consider factors such as whether your condition has been stabilized or has improved on your medicine.

Referral—permission from your primary care doctor to see a specialist or obtain certain medical services.

Specialty—care, medicines, and services for complex or rare conditions that may require extra support. This can include specialty medicines (to treat these conditions), pharmacies (that handle these medicines), and care centers (where experts treat these conditions).

Step therapy—some health plans require you to try other medicines before they will cover the requested medicine.

Summary of Benefits (SOB)—shows you how you and the health plan would share the cost for covered health services.

What to Think About When Choosing a Plan



Your health plan type affects what's covered and how decisions are made:



- **Private** (or **commercial**) **health plans** can include coverage through an employer, the **Marketplace**, a spouse, another family member, or labor union. You can also buy a health plan directly from an insurance company. The plan's policy outlines what is covered

- **For more information about Marketplace coverage:** visit go.HC.gov/marketplace-prescription-coverage



- **Government health plans** (such as **Medicare**, **Medicaid**, or Children's Health Insurance Program [CHIP]) follow federal and state rules. For more about coverage:

- **Medicare:** visit go.Medicare.gov/using-your-drug-plan

- **Medicaid:** contact your state Medicaid office or visit Medicaid.gov/about-us/contact-us

To be sure your doctor, **specialty** pharmacy, or infusion center has all your insurance information on file, consider providing a copy of the front and back of your identification card provided by your health plan:

Healthcare Company		
ID#: xxxxxx 00 John Smith 01 Jane Smith	Plan Name	Deductible/ Co-pay Office/Spec \$xx/\$xx IP/OP Hosp \$xx/\$xx Urgent/ER \$xx/\$xx Drug \$xx/\$xx Pharmacy Network
Group#: xxxxxx		

Healthcare Company
INPATIENT ADMISSION AND OUTPATIENT PROCEDURES: Uctuus, cupimolum mententilem te quitrus; nes! Ahala nos rem oribem, se pul ut aci sus, urbis poporuntris conum demoena, etod faccio consulia? llnes! Dum quam prae derit
Send claims to: Healthcare Company xx Street Address. City, ST ##### CUSTOMER SERVICE: 1-234-567-8910
website.com

These images serve as examples only and do not represent an actual health insurance ID card.

Insurance Basics (cont'd)



Understanding your Explanation of Benefits (EOB)

Your health plan sends an **EOB** after you receive medical services. It summarizes how your claim was processed. **Government health plans** may use a different name, such as a **Medicare** Summary Notice.



An EOB is **not a bill**. It explains:

- What services were covered
- What was not covered and why
- What your health plan paid
- What you may owe

It may also show claims that are still being reviewed.

Consider keeping your EOBs for your records. They can help if you have questions about your coverage, need to resolve a billing issue, or need to **appeal** a coverage decision.



TIP

You might find it helpful to review the services listed in the EOB and compare them to any bills you receive. If something looks unclear, consider calling your health plan.

Comparing Health Plan Types (cont'd)



Support for people with disabilities

Programs that assist people with disabilities are not health insurance.

They often help support people with challenging medical conditions. They can also serve as paths to enrolling in **government health plans**:



- **Supplemental Security Income (SSI):** This federal program provides financial help to people with disabilities based on need. Some diseases qualify for **compassionate allowances** under SSI. This speeds up the review of their application for SSI. People who qualify for SSI may often also qualify for **Medicaid**
- **Social Security Disability Insurance (SSDI):** People who become disabled after working for 5 of the last 10 years may qualify for this federal assistance. Children and spouses/ex-spouses of people getting SSDI may also qualify. After receiving SSDI for 2 years, a person with a disability may become eligible for **Medicare**