AMGEN®

Amgen By Your Side
Insurance and Support Guides

UNDERSTANDING HEALTH PLANS AND MAKING THE RIGHT CHOICE FOR YOU

Learn how health plans determine coverage and what to consider when choosing a plan

AMGEN BY your side

What Health Plans Cover

You may have health insurance from a private company (sometimes called a **commercial health plan**) or from a government program like **Medicare** or **Medicaid**.

If you have a commercial health plan, the insurance company's **medical policy** outlines the services and medicines your insurance will cover. What is covered by a **government health plan** is determined by federal and state laws.

Most commercial and government health plans must cover certain services, like emergency care, while others may not be covered at all. Additionally, you may still have to pay for some portion of covered services, depending on what is covered by your particular insurance policy.

You may get coverage for medical services and prescription medicines through the same health plan or through different plans. In either case, a company separate from your health insurer, called a **prescription benefit manager (PBM)**, may administer your prescription medicine coverage.

Sometimes, a health plan will cover a service or medicine that is not included in your policy if your doctor can make a good case that you need it—in other words, that it is **medically necessary**. Health plans also review and make changes to their policies as more is learned about diseases and their treatments.

Your policy provides details on what your health plan will pay for and what you will be responsible for.

For helpful definitions of all bolded terms, see the glossary on pages 21-23.

The Health Plan's Network Benefits

Most health plans sign contracts with doctors, hospitals, and other healthcare providers that agree to accept the plan's payments and rules. These doctors, hospitals, and other providers are part of the health plan's **network**.

It's important to check that the doctors and medical facilities that you use most frequently are part of your health plan's network. Most health plans require you to pay a larger portion of the cost of visiting doctors and facilities that are out of their networks.

If you get your health insurance through Medicaid, you may be limited to seeing participating providers in your state. If you are in a **Medicaid managed care plan**, you may be further restricted to seeing only those providers that are in the plan's network. (For more information on Medicaid, talk to your Amgen **Patient Access Liaison [PAL]** or **Clinical Nurse Educator [CNE]**.)

Depending on your condition, you may occasionally need to travel out of state for treatment. Your health plan is required to cover emergency services out of state, but coverage of other services out of state may be limited. There may be exceptions, such as in cases where you live in an area that borders another state and people typically cross state lines to receive services. It's important to check these rules before choosing your plan.

Your Out-of-Pocket Costs

Even when a treatment is covered and the healthcare provider is in network, that doesn't necessarily mean you will have no costs. The health plan typically pays for a portion of most treatments, with the remaining portion being your responsibility. This **cost sharing** can be in the form of **deductibles**, **co-payments**, and **co-insurance**.

Your cost sharing may be different depending on the treatment(s) you receive. Health plans cover the entire cost of some preventive services with **in-network providers**, for instance.

Your portion of the treatment cost is an important consideration when choosing a health plan. You might find that a health plan that has lower monthly **premiums** is actually more expensive for you due to higher cost sharing.

TIP: Need help understanding your insurance options? Your PAL or CNE can assist you in reviewing them. Call 1-844-469-4297 to be connected.

Explanation of Benefits

When you receive medical services and your doctor's office or treatment facility submits a claim for payment to the health plan, a commercial plan will send you an **Explanation of Benefits (EOB)**. Government health plans have other names for these, such as a Medicare Summary Notice.

These are *not* bills. They are exactly what they sound like: an explanation of your coverage. They usually include a list of the services covered or not covered, the reason that some services were not covered, how much the health plan paid, and how much you owe.

EOBs may also include information on claims that are still being reviewed for payment.

These documents are very important to keep if you disagree with your health plan's decision not to cover a service you received. (For more on what to do if you disagree with your health plan, talk to your PAL or CNE.)

TIP: If you have a question about the coverage listed on an EOB, or the charges that appear on a bill you receive later, call your health plan. Your PAL or CNE may also be able to answer questions.

Explanation of Benefits

Explanation of Benefits
(EOB)

Customer service: 1-800-123-4567

Statement date: XXXXX
Document number: XXXXX
THIS IS NOT A BILL

Member name: John Smith
Address: Street Address
City, State, Zip: City, ST 12345

Insurance plan logo

Subscriber number: XXXXX **ID:** XXXXX **Group:** ABCDE **Group number:** XXXXXX

Patient name: **Provider:** **Claim number:** XXXXXXXXX
Date received: **Payee:** **Date paid:** XXXXXXXX

Claim Detail				What your provider can charge you		Your responsibility			Total Claim Cost		
Line No.	Date of Service	Service Description	Claim Status	Provider Charges	Allowed Charges	Co-Pay	Deductible	Co-Insurance	Paid by Insurer	What You Owe	Remark Code
1	Date – Date	Medical care	Paid	$XX	$XX	$XX	$XX	$XX	$XX	$XX	Code
2	Date –	Medical	Paid	$XX	$XX	$XX	$XX	$XX	$XX	$XX	Code
			Total	$XX	$XX	$XX	$XX	$XX	$XX	$XX	

Remark Code: PDC—Billed amount is higher than the maximum payment insurance allows. The payment is for the allowed amount.

Medicare Summary Notice

Medicare Summary Notice
for Part A (Hospital Insurance)

Page 1 of 4

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

JOHN SMITH
ADDRESS NAME
STREET ADDRESS
CITY, ST 12345

THIS IS NOT A BILL

Notice for Jennifer Washington

Medicare Number	**1A23BC4DE56**
Date of This Notice	**Month XX, Year**
Claims Processed Between	**Month XX, Year**

Your Deductible Status

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

Part A Deductible: You have now met your **$XX** deductible for **inpatient hospital** services for the benefit period that began Month, XX Year

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 Claims? **YES**
See page 2 for how to double-check this notice.
Total You May Be Billed **$XX**

Facilities with Claims This Period

June 18 – June 21, 2019
Otero Hospital

1-800-MEDICARE (1-800-633-4227)

Coverage of Medicines

Health plans, both commercial and government, have a list of medicines they will cover, called a **formulary**. The formulary includes both brand-name and generic drugs. It's a good idea to check if your medicine is on the health plan's formulary before choosing a plan.

If your medicine is not listed, you may still be able to get it covered if your doctor can provide evidence that you need it for your condition—or that it is medically necessary. (For more information on the process of requesting a medicine that is not covered by your health plan, ask your PAL or CNE.)

How different kinds of medicines are covered

How your drugs are covered depends in part on where you take them or have them administered.

- Oral medicines (medicines that you take by mouth or gastrostomy tube [G-tube]): These are typically covered by the prescription drug portion of your health plan.
- Intravenous (IV) infusions: These drugs are usually given at a doctor's office or medical facility. Your health plan coverage will likely depend on where you receive the infusion. For instance, if you have Medicare, an IV infusion will be covered by Part A if you receive it while admitted to a hospital, and Part B if you receive it at your doctor's office. (For more information on how Medicare covers various services, ask your PAL or CNE.)
- Subcutaneous (SC) injections: These medicines are given as a shot under the skin. If you give yourself the injection at home, it will likely be covered like an oral medicine. If you receive it in a doctor's office, then the amount covered may be more similar to the cost of a visit to the doctor's office.

Health Plan Rules That Can Affect Coverage of Your Amgen Medicine

Coverage for Amgen medicines can vary from health plan to health plan.

Depending on your policy, you may need to meet some of the following requirements before your health plan approves coverage of an Amgen medicine:

Step requirements: Under these rules, patients must first try other medicines before the health plan will cover the requested Amgen medicine.

Prior authorization (PA): This is a process that your doctor must complete, describing the reasons you should be prescribed an Amgen medicine and why the health plan should cover the costs.

Reauthorization: This is renewal of the PA after a certain period of time. One factor considered in reauthorization is whether your condition has been stabilized or has improved on an Amgen medicine.

If your Amgen medicine is not covered

There are things you can do if your health plan does not cover an Amgen medicine:

- Your doctor may submit a **medical exception** request to your health plan, explaining that the Amgen medicine is medically necessary. If this request is denied, you have the right to **appeal** the decision. (For more information on the appeals process, talk to your PAL or CNE.)
- Some people who get insurance through their employers find that their Human Resources departments can help in encouraging the health plan to cover their medicine.
- Ask your PAL or CNE for help. This person may be able to answer questions, find support services, or connect you with patient groups that can advocate on your behalf.

Support for People with Disabilities

Programs that assist people with disabilities, though they are not health insurance, often provide important support to people who have challenging medical conditions. They can also serve as paths to enrolling in government health plans.

- Supplemental Security Income (SSI): This federal program provides financial assistance to people with disabilities based on need. Some diseases qualify for **compassionate allowances** under SSI, allowing people to speed up the review of their application for SSI. People who qualify for SSI also qualify for Medicaid.
- Social Security Disability Insurance (SSDI): People who become disabled after working for a number of years may qualify for this federal assistance. Disabled children of people who have worked may also qualify. After receiving SSDI for 2 years, a disabled person is eligible for Medicare.

Government health plans will provide you with an identification card as proof that you have insurance coverage. Your doctors' offices will need the information on this card to bill your health plan for the services they provide.

Choosing a Health Plan

You may already have insurance. However, at some time during the course of your treatment you may have the chance to choose a new health plan or to keep the one you have. This may come about because your employer adds a new health plan to its benefit options during open enrollment or because you have what's known as a **qualifying life event**. These events include:

- Loss of your current health coverage due to circumstances such as changes in employment, losing eligibility for a government health plan, or "aging out"—becoming too old (age 26 years in most cases) to be covered by a parent's health plan
- Changes in your household, such as a marriage or divorce, the birth or adoption of a child, or a death in the family
- Moving to a new home or school campus

If and when you have the opportunity to choose health plans, there are a number of things to consider, as highlighted here. Always speak to someone at your health plan if you have specific questions.

Helpful worksheets to keep you organized when choosing a health plan can be found on pages 18-19.

Coverage That Meets Your Needs

As mentioned earlier, your health plan's medical policy will determine the treatments and services that are covered. It's worth checking your policy, before choosing a health plan, to determine coverage for services to treat your condition. Look for information about:

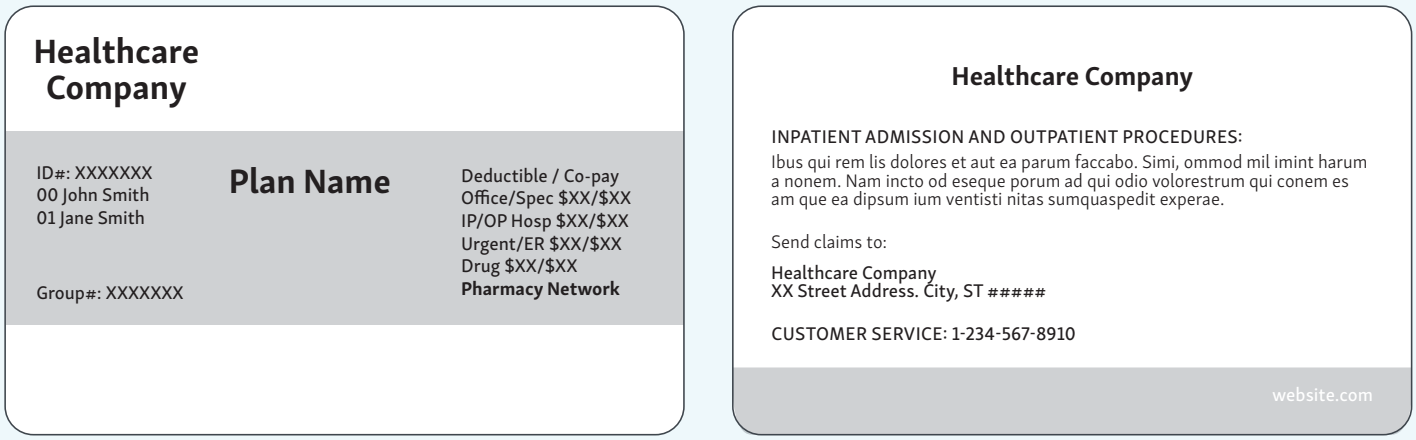
- Doctor's visits
- Medical tests, including labs and imaging
- Medicines

TIP: If you have questions about what's covered, contact a representative of the health plan, or your Amgen PAL or CNE for help.

Private or Commercial Health Plans

These health plans are offered by private insurance companies. You may get coverage through a private or commercial health plan from your employer, your labor union, or a spouse or family member. You also may purchase it yourself from an insurance company, from an insurance agent or broker, or through an online marketplace sometimes called an **insurance exchange** (see more information on page 11).

As with a government plan, your **private health plan** will provide you with an identification card as proof that you have insurance coverage. Your doctors' offices will need the information on this card to bill your health plan for the services they provide. Some cards list the deductible and co-pay costs for certain services or prescription drugs.



TIP: To be sure your PAL or CNE has all your insurance information on file, provide a copy of the front and back of your card.

Comparing features of private or commercial health plans

When reviewing health plan options, it's important to consider how easy it will be to see the doctors and other providers on your current healthcare team and whether you will be charged extra to see them. For more on costs to consider when choosing a health plan, ask your PAL or CNE.

The table on the following page lists common types of health plans and how they compare.

Type of Plan	Description	Designated Primary Care Provider?	Specialist Access	In Network	Out of Network
Health maintenance organization (HMO)	Limited **networks** and potential coverage restrictions, usually resulting in lower **premiums** and smaller **out-of-pocket costs**	Required	Need **referral** from primary care provider	Limited doctors, hospitals, and other providers	Not covered, except in emergencies and, in some cases, when there is no **in-network provider** who can treat you
Preferred provider organization (PPO)	Has a "preferred" network of providers that is generally wider than an HMO's	Not required	No referral needed, easier to access	Larger list of doctors, hospitals, and other providers	Covered, but will reimburse less of the cost than for in-network providers
Exclusive provider organization (EPO)	Combination of an HMO and PPO: Like a PPO, doesn't require referral for a specialist; like an HMO, won't pay out-of-network providers	Not required	No referral needed, easier to access	Limited doctors, hospitals, and other providers	Not covered, except in emergencies
Point-of-service (POS) plan	Different combination of HMO and PPO: Requires a referral for a specialist, like an HMO; allows access to out-of-network providers at an increased cost, like a PPO	Required	Need referral from primary care provider	Larger list of doctors, hospitals, and other providers	Covered, but will reimburse less of the cost than for in-network providers
Fee-for-service (FFS) or indemnity	You may visit any doctor, hospital, or other provider, but may have to pay more of the cost	Not applicable	Not applicable	Not applicable	Not applicable
High-deductible health plan (HDHP)	Any of the health plan types above that require you to pay a higher amount out of pocket (your **deductible**) before the health plan makes payments to you or your provider; employers often offset the cost of this higher deductible	Features of an HDHP will depend upon which category above the HDHP falls into.			

Any of the health plans above may also have tiered provider networks, in which health plans rank the doctors and hospitals by quality and cost. 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 top-tier in-network provider.

Generally, the smaller the provider network and the more limited the choices in your health plan, the less you will pay in premiums for your health plan. But other factors also contribute to your costs, including deductibles and how much you will pay for treatment that's not covered.

Know your coverage

- If you get health insurance through a private company:
  - Find out if your health plan has a case manager or patient advocate who can become your contact person.
  - Review your policy. You may be able to find your policy with the help of a case manager or patient advocate, or by:
    - Looking on your health plan's website or in its patient portal
    - Calling the customer service number on your insurance identification card to request it. Ask for information on coverage of the Amgen medicine that has been prescribed for you.
    - Asking your Human Resources department, if you get your health insurance through your employer
    - If you have Medicare or Medicaid, ask your PAL or CNE at Amgen for guidance.
    - However you get your health insurance, check periodically to see how your coverage may have changed.

Online marketplaces or insurance exchanges

If you need to buy health insurance, one option is to buy it through an online marketplace, or insurance exchange, operated by your state or the federal government.

The types of plans and their networks are the same for the exchanges as for the commercial plans listed on page 9.

In addition, health plans on the exchanges are categorized by metal tiers: Bronze, Silver, Gold, and Platinum. In general, the premiums are lowest and the out-of-pocket costs highest for Bronze plans; the premiums are highest and the out-of-pocket costs lowest for Platinum plans. Based on your income, you may apply for a reduced premium. Additional assistance with out-of-pocket costs may be available if you choose a Silver plan.

Learn more at **healthcare.gov**.

Government Health Plans

Many Americans get their health insurance through government programs. Health plans funded by the state and/or federal government include:

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," whose income is too high to otherwise qualify and who must pay a portion of their medical bills, or a "share of cost," each month (in some states) • 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, including some with cystinosis
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, or DOD)	• 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
Veterans Administration (VA) healthcare	• Former military, National Guard, or Reserve members

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

Medicaid

Medicaid is funded by both state and federal governments, but it is operated by the states only. States must operate their Medicaid programs according to broad federal guidelines, but they have flexibility in how they structure their programs.

That means that the rules for who is eligible and what is covered under Medicaid vary from state to state.

TIP: To learn whether you qualify for Medicaid and how to apply, contact your state's Medicaid office. You can get the number by visiting **medicaid.gov**. Click on "About Us," then "Contact Us," then select your state from the drop-down menu on the right. You may also call 877-267-2323, then press 3.

Children's Health Insurance Program

Children in families who earn more than the Medicaid limit in their state can get health insurance through the Children's Health Insurance Program (CHIP), which generally offers coverage at a lower cost than other health plans. Children must be aged 18 years or younger to qualify and meet any other state eligibility requirements.

While coverage varies from state to state, all states' CHIP plans must include:

- Routine checkups
- Immunizations
- Doctor visits
- Prescriptions
- Dental and vision care
- Inpatient and outpatient hospital care
- Laboratory and x-ray services
- Emergency services

If you apply for Medicaid coverage in your state, you can also find out at that time if your children can be covered by CHIP.

TIP: For information about CHIP in your state and how to apply for coverage, visit **insurekidsnow.gov.** Click on "Find Coverage for Your Family" and then click your state on the map.

Some doctors' offices will not accept Medicaid or CHIP coverage. If you or your child is covered through one of these programs, check with the office staff before making an appointment.

Medicare

Medicare is a national insurance program operated by the federal government. It covers people:

- Aged 65 years and older
- Younger than age 65 years with certain disabilities
- With end-stage kidney disease, including some patients with cystinosis

Medicare coverage is split into 4 parts: A, B, C, and D.

A&B Medicare Parts A and B

Part A is sometimes referred to as "hospital insurance," but it covers some care outside of the hospital as well, including medical care in a nursing home and some home healthcare.

Medicare Part B is sometimes called "medical insurance." It covers such services as visits to your doctor and supplies to treat your condition. It also covers a limited amount of medicines, such as injections you get in a doctor's office.

Together, Medicare Parts A and B are sometimes called "original Medicare."

C Medicare Part C (Medicare Advantage Managed Care Plans)

Private insurance plans under Medicare Part C are called Medicare Advantage. They must cover the same services as Medicare Part A and Part B. They may offer additional benefits as well, including some prescription drug coverage.

D Medicare Part D

This part of Medicare is sometimes called the prescription drug benefit. Part D prescription drug plans are sold through private insurance companies approved by the federal government. You are eligible for Medicare Part D if you are enrolled in Part A or Part B. You will generally need Part D for Medicare to cover your Amgen medicine.

Medicare pays for part of the costs of the prescription drug coverage. How much you pay depends on which plan you choose.

Part D prescription drug plans list the medicines they cover in different tiers. Your out-of-pocket cost for medicine will depend on which tier the medicine is listed in. Part D plans from different companies may list the same medicine in different tiers.

As with other health plans, a Medicare Part D plan may or may not cover your Amgen medicine. Alternatively, your medicine may be included but listed in a tier that will result in higher out-of-pocket costs for you.

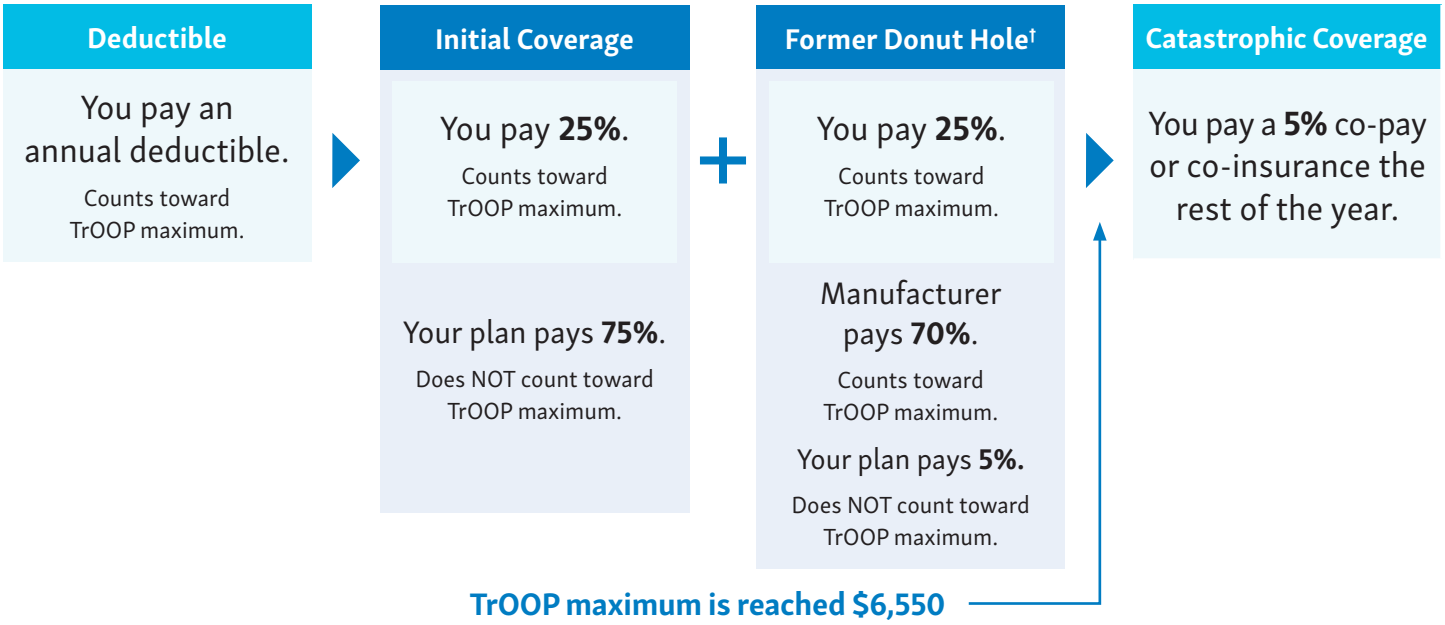
Medicare Part D rules allow you to request that your medicine be covered entirely or covered at a lower cost through a **formulary exception** or **tiering exception**. A formulary exception asks that your medicine be included on the health plan's list of medicines approved for coverage (its formulary). A tiering exception asks that your medicine be placed in a different tier. As with other requests for

medical exceptions, you and your doctor must show that your medicine is medically necessary—that you need it to treat your condition.

Once coverage of your Amgen medicine is approved, you must still prepare for out-of-pocket costs with a Part D prescription plan.

Once you reach your annual deductible, you will pay 25% of the cost for brand-name and generic medicines until you reach the limit for **true out-of-pocket (TrOOP) costs**. During this time, the remaining cost of your medicine is covered by your health plan and/or the manufacturer of the medicine. What you pay and what the manufacturer pays both count toward the TrOOP, but the amount paid by your plan does not. In 2021, the TrOOP maximum will be $6,550.

Phases of coverage for Medicare Part D



†These costs are for brand-name drugs. Your plan may have a different co-pay for generic drugs.

Once you reach the TrOOP maximum, you move into the catastrophic coverage phase for the remainder of the calendar year. In this phase, you will pay a 5% co-pay or co-insurance for your prescription medicines and the other 95% will be covered. To learn more about Medicare coverage and choosing the right plan, go to medicare.gov.

Medigap: Help with Medicare out-of-pocket costs

Whatever plan you might choose under Medicare, you will have some cost sharing, such as co-payments, deductibles, and co-insurance. If you choose original Medicare—Parts A and B—you can also buy Medicare Supplemental Insurance, which is extra coverage sometimes called **Medigap** because it covers the gaps in Medicare benefits.

Medigap policies are offered by private companies and regulated by state and federal laws. They are labeled with letters A through J, with benefits for each category of plan (Plan A, Plan B, etc) standardized no matter which company sells you the policy. You must pay a monthly premium for Medigap.

Medigap policies are not available with Medicare Advantage (Part C).

If You Have More Than One Health Plan

Whenever someone is covered by more than one health plan, there must be a **coordination of benefits** between the plans. One plan is designated the primary health plan, and the other is the secondary health plan. The primary health plan pays first, up to the limits of its coverage. Then the secondary health plan kicks in.

State and federal rules determine which plan is primary and which is secondary. The chart below outlines several scenarios and which plan will usually act as the primary plan.

Scenario	Primary Plan	Secondary Plan
Patient has a commercial plan AND Medicaid	Commercial	Medicaid
Patient is covered by 2 commercial plans	Plan patient has had for the longer amount of time	Plan patient has had for the shorter amount of time
Child is covered by both parents' health plans	Determined by the **birthday rule**: The primary plan is the plan belonging to the parent whose birthday comes first in the calendar year, and the secondary plan is the plan belonging to the parent whose birthday comes second in the calendar year	
Patient has Medicare AND Medicaid OR Medigap	Medicare	Medicaid OR Medigap
Patient has Medicare AND a plan from his or her employer	Whether Medicare is the primary or secondary plan depends on the patient's age and the size of his or her employer†	

†If you have end-stage kidney disease, there is an exception: Medicare is the secondary payer for the first 30 months, then becomes the primary payer.

Medicaid as your second health plan

If you qualify for Medicaid, you may use it as secondary insurance even if you are already covered by a private or commercial health plan (through your employer, perhaps). As a **payer of last resort**, Medicaid can help pay for medical costs that your commercial health plan does not cover. If your commercial health plan pays 80% of your medical costs, for instance, Medicaid can cover the other 20%. Or you might have good medical insurance through your primary plan but limited coverage for vision or dental care, which Medicaid may partly pay.

Medicare and Medicaid together

Some people qualify for both Medicare and Medicaid and can use benefits from both government health insurance plans. For these people, known as "**dual eligibles**" or "**dually eligible**," Medicaid, as the payer of last resort, fills in the gaps in Medicare coverage.

TIP: Talk to your PAL or CNE if you think you might qualify for both Medicare and Medicaid and want to know how the health plans work together.

Medicare with other insurance plans

As mentioned earlier, Medicare is sometimes one piece of a person's health insurance. Medicare may be used jointly with a Medigap plan, for instance. It can also be used with a commercial health plan from your employer if you continue working after age 65 years.

When used with Medicaid or Medigap, original Medicare is the primary insurance. When used with an employer plan, whether Medicare is primary or secondary typically depends on the size of the employer. Medicare has specific rules for coordination of benefits with other health plans for those patients with end-stage kidney disease. (For more information about primary and secondary insurance, ask your PAL or CNE.)

The worksheet on page 20 can help you keep track of important information for all of your health plans.

Health Plan Choices Worksheet

Use this worksheet as a place to organize your research about choosing a health plan.

1. Health plans that are available to me (for example, commercial plans offered by your employer or government plans for which you qualify):

_____

_____

2. Doctors, hospitals, and facilities that are important to me:

_____

_____

Which plans from question #1 have these doctors and facilities in their networks?

_____

_____

3. Coverage that is important to me (include coverage for medicines):

_____

_____

Which plans from question #1 cover these treatments?

_____

_____

4. How out-of-pocket costs compare among the health plans listed in question #1:

Plan:	Costs:
_____	_____
_____	_____
_____	_____
_____	_____

5. Questions I want to ask the health plans or my PAL or CNE:

_____

_____

Health Plan Call Record

Use this sheet to keep track of information you receive from your health plan about topics like coverage for your medicine, PA requirements, or the appeals process in case coverage is denied.

Date of call: _____ Name of person I spoke with: _____

Best phone number or email to contact person I spoke with: _____

Reference or case number: _____

Topic that we talked about: _____

Information I received: _____

_____

Next steps: _____

_____

_____

Date of call: _____ Name of person I spoke with: _____

Best phone number or email to contact person I spoke with: _____

Reference or case number: _____

Topic that we talked about: _____

Information I received: _____

_____

Next steps: _____

_____

_____

Health Plan Information

Use this sheet to keep track of important information for each of your health plans.

Name of health plan: _____

Phone number: _____

Website: _____

ID or policy number: _____ Group number: _____

Portal website: _____

Portal login: _____ Portal password: _____

Name of health plan: _____

Phone number: _____

Website: _____

ID or policy number: _____ Group number: _____

Portal website: _____

Portal login: _____ Portal password: _____

Name of health plan: _____

Phone number: _____

Website: _____

ID or policy number: _____ Group number: _____

Portal website: _____

Portal login: _____ Portal password: _____

Glossary

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

Birthday rule — when a child is covered by both parents' health plans, this is the rule used to determine which health plan is primary and which is secondary. The primary plan is the one belonging to the parent whose birthday comes first in the calendar year.

Catastrophic coverage — in Medicare Part D prescription drug plans, the coverage that kicks in once you have reached a set maximum level in out-of-pocket costs. Once you reach this point, you pay only a small co-insurance or co-payment amount for prescription drugs.

Clinical Nurse Educator (CNE) — If you're a patient on ACTIMMUNE® (Interferon gamma-1b) and you have enrolled in the Amgen By Your Side Program, you are assigned a Clinical Nurse Educator (CNE). Your CNE provides you with dedicated, one-on-one support. They work directly with you to answer non-medical, logistical questions and provide support once you have been prescribed ACTIMMUNE® and you have completed enrollment.

Co-insurance — the portion of a covered medical service that you pay (for example, 20%) after you have paid your deductible.

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.

Coordination of benefits — when a person is covered by more than one health plan, the process of determining which plan will have the primary responsibility for payment and the extent to which other plans must contribute.

Co-payment — the fixed amount of a covered medical service that you pay (for example, $20) after you have paid your deductible.

Cost sharing — the share of costs for covered medical services that you pay out of pocket. Cost sharing includes co-insurance, co-payments, and deductibles.

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

Donut hole — a coverage gap in Medicare Part D prescription drug plans that occurs after your medicine expenses go above the initial coverage limit on the plan, but before you reach catastrophic coverage.

Dual eligibles or dually eligible — people who qualify to receive both Medicare and Medicaid.

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, the reasons it may not have covered some services, how much the health plan paid, and how much you may owe.

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

Formulary exception — coverage of a medicine not listed on the health plan's formulary.

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

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

Insurance exchange — online marketplace where you can compare and purchase health insurance plans.

Medicaid — 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.

Medical exception — coverage for a medicine or treatment that is not otherwise covered by the health plan.

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

Medical policy — a set of guidelines for the services and medicines that a health plan covers.

Medicare — government-funded health plan primarily for people aged 65 years and older, certain people with disabilities, and people with end-stage kidney disease.

Medigap — extra Medicare insurance sold by private companies to fill in gaps in Medicare coverage.

Network — a group of healthcare providers 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. You will not have to pay more than the yearly maximum for out-of-pocket costs set by your health plan.

Patient Access Liaison (PAL) — starting a new medicine or treatment often comes with a lot of questions. Once enrolled in the Amgen By Your Side Program, you will be paired with a Patient Access Liaison (PAL). Your PAL provides you with dedicated, one-on-one support. They work directly with you to answer non-medical, logistical questions and provide support once you have been prescribed an Amgen medicine and you have completed enrollment.

Payer of last resort — the health insurer that pays last when someone has more than one health plan.

Premium — the amount you pay for your health plan every month.

Prescription benefit manager (PBM) — a company, separate from your health insurer, that may administer your prescription medicine coverage.

Prior authorization (PA) — a process that your doctor must complete, describing the reasons you need an Amgen medicine and why the health plan should cover the costs.

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

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 — this is renewal of the PA after a certain period of time. One factor considered in reauthorization is whether your condition has been stabilized or has improved on an Amgen medicine.

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

Step requirements — under these rules, patients must first try other medicines without success before the health plan will cover the requested Amgen medicine.

Tiering exception — coverage of a medicine in a different "tier" than the one where it is listed, generally lowering its cost.

True out-of-pocket (TrOOP) costs — payments for covered Part D medicines that count toward your drug plan's out-of-pocket cost limit. Your yearly deductible, co-insurance or co-payments, and what you pay in the coverage gap all count toward this out-of-pocket limit.

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