Biogen

Navigating Insurance & Support Programs

A Guide For People With Relapsing Multiple Sclerosis (MS)

Table of Contents

Welcome to the Insurance Guide

Understanding Health Insurance

Navigating Coverage and Access to Your Medications

Biogen Support Services

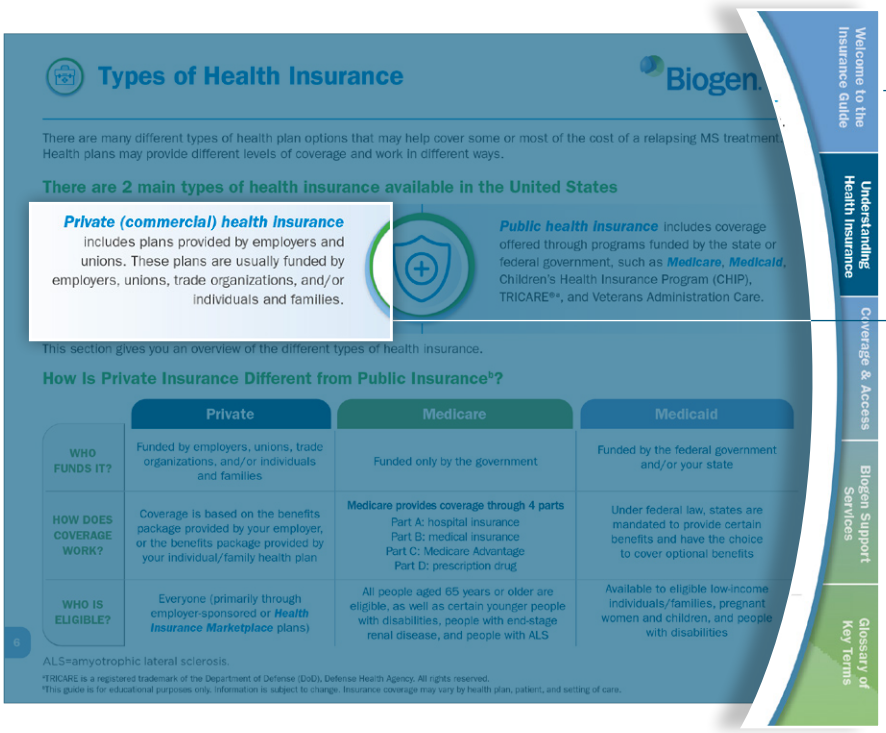
Glossary of Key Terms

Biogen

Welcome to the Insurance Guide

Welcome to the Insurance Guide

If you have relapsing MS, you may have concerns about how to pay for your treatment. This guide can help you learn about health insurance and help you make informed choices regarding your care. You can use this guide to learn about types of health plans, understand how medications may be covered by your health plan, and know what support programs are available to you. As soon as you are prescribed a Biogen treatment, **Biogen Support Services** can provide you with financial, insurance, and treatment education and support. Always talk to your doctor if you have questions about managing your relapsing MS-related healthcare costs.



How to Navigate This Guide

Click on any of the navigation tabs across the right side of each page to go directly to that section of the guide. Click on any page numbers listed throughout the guide to go directly to that page. You may also click on any website name to be directed to that webpage.

Definitions for words that are ***blue, bold, and italic*** in this brochure can be found in the Glossary of Key Terms on page 41.

Biogen Support Services is here to answer your questions about health plan options. Call 1-800-456-2255, Monday through Friday, 8:30 AM to 8 PM ET.

Biogen

Understanding Health Insurance

Types of Health Insurance

There are many different types of health plan options that may help cover some or most of the cost of a relapsing MS treatment. Health plans may provide different levels of coverage and work in different ways.

There are 2 main types of health insurance available in the United States

Private (commercial) health insurance includes plans provided by employers and unions. These plans are usually funded by employers, unions, trade organizations, and/or individuals and families.

Public health insurance includes coverage offered through programs funded by the state or federal government, such as ***Medicare***, ***Medicaid***, Children's Health Insurance Program (CHIP), TRICARE®[a], and Veterans Administration Care.

This section gives you an overview of the different types of health insurance.

How Is Private Insurance Different from Public Insurance[b]?

	Private	Medicare	Medicaid
WHO FUNDS IT?	Funded by employers, unions, trade organizations, and/or individuals and families	Funded only by the government	Funded by the federal government and/or your state
HOW DOES COVERAGE WORK?	Coverage is based on the benefits package provided by your employer, or the benefits package provided by your individual/family health plan	**Medicare provides coverage through 4 parts** Part A: hospital insurance Part B: medical insurance Part C: Medicare Advantage Part D: prescription drug	Under federal law, states are mandated to provide certain benefits and have the choice to cover optional benefits
WHO IS ELIGIBLE?	Everyone (primarily through employer-sponsored or ***Health Insurance Marketplace*** plans)	All people aged 65 years or older are eligible, as well as certain younger people with disabilities, people with end-stage renal disease, and people with ALS	Available to eligible low-income individuals/families, pregnant women and children, and people with disabilities

ALS=amyotrophic lateral sclerosis.

[a]TRICARE is a registered trademark of the Department of Defense (DoD), Defense Health Agency. All rights reserved.

[b]This guide is for educational purposes only. Information is subject to change. Insurance coverage may vary by health plan, patient, and setting of care.

Open Enrollment

Biogen

What is Open Enrollment?

Open enrollment is a period of time when you can make changes to your health or drug plan for the next year. Open enrollment is a great opportunity to review your plan benefits and evaluate whether your current coverage is meeting your needs. You can keep your current plan, or you can compare plans to find one with the right coverage for you. Even if you just enrolled in a health plan during a previous enrollment period, you will need to choose your plan for the next year during this open enrollment period.

Medicare open enrollment is from **October 15 to December 7** each year. Your coverage will begin on January 1 of the next year as long as the plan gets your request by **December 7**.[a]

If you sign up for private health insurance through your job, you can enroll when you are hired or during your set open enrollment period (usually beginning late in the calendar year and continuing until December). If you miss that period, you will have to wait until the next open enrollment period or until you have a qualifying life event. Examples of qualifying life events include losing other coverage, getting married, having a baby, or a change in residence.

If you qualify, you can apply and enroll in Medicaid any time of year.

Check with your plan, employer, or benefit manager for the actual dates of open enrollment.

Medicare and Medicare Advantage open enrollment is from October 15 to December 7 each year. Your coverage will begin on January 1 of the next year as long as the plan gets your request by December 7.[a]

[a]If you are already enrolled in a Medicare Advantage plan and want to switch to a different Medicare Advantage plan or switch to Original Medicare, you can also do this once from January 1 to March 31 each year.

Private (Commercial) Health Insurance

What Types of Private Health Plans May Be Offered By My Employer?

Employer-Sponsored Health Plan

An employer-sponsored health plan is when a business pays for its employees' health insurance. It is usually part of an overall benefits package. Employees may be required to pay a portion of the costs. Most private (commercial) health insurance in the US is sponsored by employers.

Consumer-Driven Health Plan and High-Deductible Health Plan

Consumer-driven health plans allow you to control how your healthcare dollars are spent. ***High-deductible health plans*** are a type of consumer-driven health plan that are becoming more popular. You pay less toward your ***premium*** (usually monthly). But you pay 100% of the costs toward your healthcare expenses until your ***deductible*** is met. When your deductible is met, ***coinsurance*** applies. Coinsurance means that you share a percentage of the costs when your health plan.

A consumer-driven health plan can be offered through 3 types of accounts

1. A health reimbursement account (HRA), funded by your employer
2. A ***flexible spending account*** (FSA), funded by you and potentially your employer
3. A ***health savings account*** (HSA), funded by you

What Types of Private Health Plans May Be Offered By My Employer?

Health Reimbursement Account

A health reimbursement account, also called an HRA, pays for covered healthcare expenses. You must meet a set deductible each year before your health plan benefits begin. Any funds in your HRA that you don't use by the end of the year automatically roll over into the next year. They are added to the annual contribution from your employer. This means that the higher the balance in your HRA, the less you have to pay out of pocket.

Flexible Spending Account

A flexible spending account, also called an FSA, is an account that you put money into to pay toward certain ***out-of-pocket*** healthcare costs. The money you contribute to an FSA is not taxed.

Employers may contribute to your FSA, but they don't have to.

The amount you put into your account can only be changed

- **During open enrollment**
- **When there is a change in your family or employment status**

The amount contributed to an FSA is limited per employee and is subject to change from year to year. Unlike an HSA or HRA, employers may require you to spend all of the money in your FSA within the plan year, as most do not roll over funds into the next year. Choose the amount you expect to use carefully.

What Types of Private Health Plans May Be Offered By My Employer? (cont'd)

Biogen

Health Savings Account

A health savings account, also called an HSA, is a type of savings account that allows you and your employer to set aside money for current and future healthcare expenses. You can open an HSA through your bank. You don't pay taxes on this money. The amount contributed to an HSA is limited and subject to change from year to year.

An HSA can be used only if you have a high-deductible health plan. Here are some of the benefits of these plans

- They may lower your overall healthcare costs by using untaxed money in an HSA to pay for expenses before you reach your deductible and other out-of-pocket costs, like ***copays*** for your relapsing MS treatment
- Unlike an FSA, HSA funds roll over year to year if you don't spend them
- An HSA may earn interest

Overview of Account Types

HRA	FSA	HSA
Only your employer can fund it	Flexibility in the amount you want to contribute	Structured monthly premiums
Any unused money can roll over into the following year	Plan on using all of the money you contribute within the year, as contributions do not roll over (employer may offer some grace periods)	Any unused money can roll over into the following year
Your employer contributes a set amount	Contribution amounts can be adjusted only at open enrollment or with a change in employment or family status	Flexibility to change how much you contribute to the account at any point during the year

What Types of Private Health Plans May Be Offered By My Employer? (cont'd)

Biogen

Types of Managed Care Plans

Health maintenance organization (HMO)

HMO plans coordinate care through a network, or group, of providers. In this type of plan, you usually choose a ***primary care physician*** (PCP). This doctor coordinates all of your care and provides basic healthcare needs. HMO plans require referrals to see specialists, and if you choose to see a provider that is not in your network, you may have to pay all of the out-of-pocket costs unless it is a true medical emergency.

Point-of-service (POS)

POS plans also require you to get a referral from your PCP to see a specialist. But you will pay less if you use providers or hospitals that are in the plan's network. You can also go to providers who are ***out-of-network***, but at a higher cost.

Preferred provider organization (PPO)

PPO plans also have care networks. But they are more flexible in your choice of providers. If you choose to see a doctor who is not in the network, you may have to pay more than you would for an ***in-network*** provider. But most plans will still cover a portion of the bill. You may also have access to out-of-state providers that are considered in-network.

Exclusive provider organization (EPO)

EPO plans also have care networks and will not cover out-of-network care unless it is an emergency.

What Types of Private Health Plans May Be Offered By My Employer? (cont'd)

Biogen

Fee-for-Service or Indemnity Plan

In a ***fee-for-service*** (FFS) or indemnity plan, both you and your health plan pay a portion of the costs for each visit or service.

The plan pays its share in one of 2 ways

It pays the provider directly

It pays you back after you file an insurance claim for each expense that is covered

These plans often offer more choices of providers or hospitals. But they tend to cost more.

If you work for yourself or do not have coverage from another source, you can buy individual insurance through the Health Insurance Marketplace, which is described in greater detail on the next page.

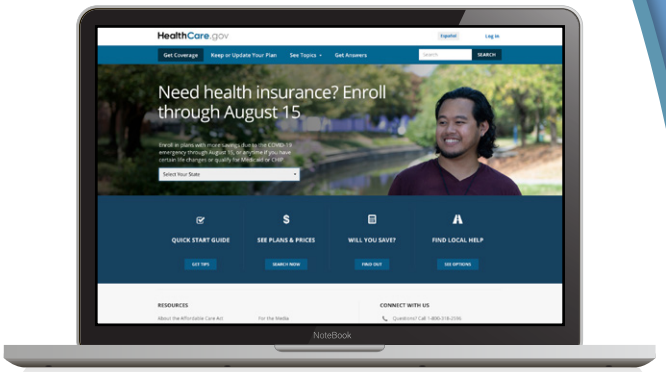
What Is the Health Insurance Marketplace?

If you do not have health insurance through your job, you may be able to get private insurance through the Health Insurance Marketplace.

The Health Insurance Marketplace is a place where you can you shop for and enroll in an affordable health insurance plan. In most states, it is run by the US federal government through HealthCare.gov. Some states run their own Marketplaces.

When you apply for coverage through the Health Insurance Marketplace (individual or family), you will be asked to provide income and household information. You will find out if you are eligible for

- Premium tax credits and other savings that may help make insurance more affordable
- Coverage through Medicaid in your state



If you visit HealthCare.gov, you will be prompted to select your state or enter your ZIP code. If you live in a state that runs its own Marketplace, you will automatically be sent to the Marketplace website run by your state.

All plans that offer coverage through the Health Insurance Marketplace must cover certain healthcare services. Some that may impact patients with relapsing MS include

- Outpatient care (medical treatment outside of a hospital)
- Emergency services
- Hospitalization
- Mental health services, including counseling and psychotherapy
- Prescription drugs
- Services and devices to help people with disabilities or chronic conditions
- Laboratory services
- Preventive and wellness services
- Chronic disease management

Be sure to look for a plan that covers the services you need for all of your healthcare, including your relapsing MS treatment, at an affordable price.
See page 36 for questions to consider.

How Much Does Private Health Insurance Cost?

Biogen

Finding a plan that is affordable starts with knowing the real costs of coverage, which can be hard. Monthly premiums, deductibles, and medication costs all have to be considered. Sometimes the plan that seems the least expensive may end up costing more, or may not provide enough coverage. The table below shows some examples of coverage and costs.

Note: These numbers are just examples. They are not meant to show actual plan coverage and costs. Contact your insurance plan for actual coverage and costs.

Examples of Health Plan Coverage and Costs

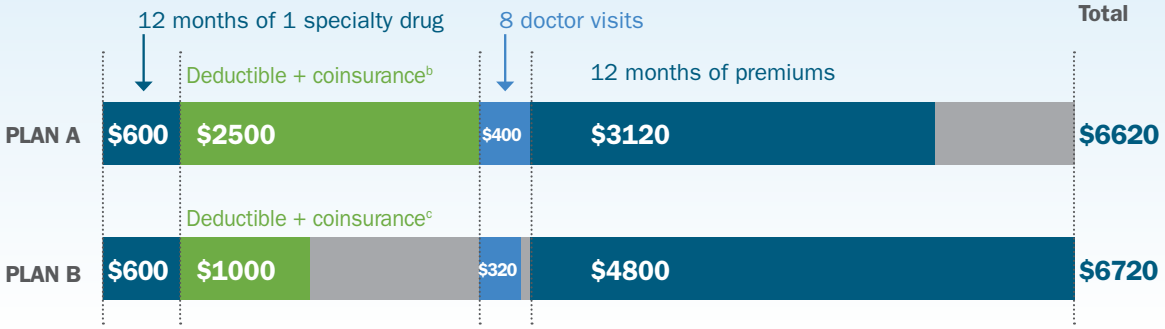
	Monthly premium (individual)	Patient copay for 1 doctor visit	Deductible/ coinsurance/out-of-pocket maximum[a]	Copay for 1 specialty drug
PLAN A (high deductible/ low premium)	$260	$50	$2000 50% $6000	$50
PLAN B (low deductible/ high premium)	$400	$40	$500 80% $4000	$50

[a]This example reviews expenses for services covered within your network. Be sure to find out the out-of-pocket maximum when choosing a plan. This is the amount you will pay before your insurance plan covers the rest of the remaining balance.

To understand the difference in total costs between these 2 types of plans, look at what you would pay if you had

- 12 months of premiums
- 8 doctor visits in 12 months
- $3000 for tests and other medical treatments during the year that count towards your deductible
- 12 months of 1 ***specialty drug***

Sample Healthcare Costs for Plan A and Plan B



In this example, a lower-deductible health plan with a higher premium would cost $100 more than a high-deductible health plan with a lower premium.

That is why it is important to think about all of your healthcare costs before choosing a plan that is right for you.

[b]You pay a $2000 deductible, then the plan covers 50% of the remaining $1000. You pay $500 in coinsurance.
[c]You pay a $500 deductible, then the plan covers 80% of the remaining $2500. You pay $500 in coinsurance.

What Is Medicare?

Biogen

You may think of Medicare as the federal health insurance program for people aged 65 years or older. But did you know that Medicare can also cover younger people who become disabled due to conditions like relapsing MS?

Medicare may be able to cover the costs of your doctor and hospital visits. It may also cover many of your prescriptions.

Choosing the right Medicare plan is a big decision.
Here are some things to think about when considering different Medicare plans:

You may need more than 1 plan (1 for your prescription and 1 for your doctor visits)

There are set times to enroll in Medicare. Find out when you need to sign up

You may be able to get help paying for your relapsing MS care from your state or other resources

How Do I Know if I Qualify for Medicare?

Medicare is an optional insurance plan offered by the government. You may be able to get Medicare if you

- Are age 65 or older
- Are younger than age 65 and disabled
- Have permanent kidney failure (called end-stage renal disease) or ALS

Four Parts of Medicare

Biogen

Part A is hospital insurance

Part A covers hospital visits, nursing home care, hospice care, and some home healthcare services.

Part B is medical insurance

Part B covers outpatient care (doctor's office visits and visits to treatment centers for injections), some home healthcare services, medical equipment, wellness services, lab tests, and select preventive screenings.

Part B may cover some relapsing MS treatments that are infused, but there may be access restrictions on other infused relapsing MS treatments.

Parts A and B are known as "Original Medicare." If you are age 65 or older and receiving Social Security benefits OR are younger than age 65 and disabled, you are automatically enrolled in Part A and Part B. You will receive your Medicare card in the mail.

You can sign up 3 months before you turn 65 if you are not receiving Social Security benefits.

Part C is also called Medicare Advantage (MA)

Part C plans are sold by private insurance companies approved by Medicare. These optional plans include all services covered under Part A and Part B, with many offering prescription drug coverage. Part C may offer additional benefits as well, such as dental, vision, or other services.

Part D is prescription drug coverage

Part D is an optional benefit that covers medicines prescribed by your doctor. These are drugs you take yourself (pills that you swallow, injections you give yourself, inhaled treatments). Part D plans are sold by private insurance companies approved by Medicare.

There are many Part D plans, and monthly premiums vary by plan and depend on your income. You can sign up for a Part D drug plan if you have only Part A and/or Part B, or if you have an MA (Part C) plan that does not offer drug coverage.

Be sure to compare MA and Part D plans to see what may be right for you. To learn more, go to www.medicare.gov/find-a-plan or contact Biogen Support Services by calling 1-800-456-2255, Monday through Friday, 8:30 AM to 8 PM ET.

When Can I Sign Up for Original Medicare (Part A and Part B)?

Biogen

You can enroll for Original Medicare during certain times of the year. The enrollment period may also depend on your age and if you have had Medicare in the past.

Initial Enrollment Period	General Enrollment Period	Special Enrollment Period
When you turn age 65. You can sign up 3 months before the month you turn age 65 or up to 3 months after the month you turn age 65.	Each year, from **January 1 to March 31,** you have the chance to sign up if you did not enroll at age 65. **Your coverage will start on July 1.**	If you have a health plan through your job, **you can sign up for Part A and/or Part B at any time,** as long as you or your spouse is still working. If you lose your health insurance at your job, you can sign up for Part A and/or Part B during the 8 months after coverage ends.

For more information, please see the section on Open Enrollment found on page 7.

If you have relapsing MS and can no longer work, you may qualify for Medicare. If you have questions, call 1-800-MEDICARE (1-800-633-4227) or go to www.medicare.gov.

How Do I Sign Up for Medicare and What Can I Expect?

Biogen

You can sign up for Medicare in 2 ways:

Sign up by telephone

Call the Social Security office at **1-800-772-1213**

Sign up online

Sign up online at www.ssa.gov/benefits/medicare

If you are disabled, you will be enrolled in Part A and Part B without having to sign up. You will be automatically enrolled by your 25th month of receiving disability benefits through Social Security and will get your Medicare card in the mail. You will also start paying a Part B premium. The amount of that premium will vary from year to year.

If you have worked in the past, but cannot now because of your relapsing MS, you may qualify as disabled. You need to apply with Social Security. For more information, call Social Security at 1-800-772-1213 or go to www.ssa.gov/disability.

The Medicare Prescription Drug (Part D) Standard Benefit

If you have a prescription plan with Medicare and you do not get Extra Help (see page 22), you likely have the standard benefit.

There are typically out-of-pocket costs that go along with this type of benefit

- Monthly premiums
- Annual deductible
- Copays or coinsurance

You may be able to get help paying for your medicines from

- National and community charitable programs
- Your state pharmaceutical assistance program
- Extra Help from Medicare Part D

Your copay may change with the amount of money you spend on prescriptions during the year, also called your true ***out-of-pocket*** costs. People who have the standard benefit will pay 25% of brand-name drug costs until the true out-of-pocket costs reach an amount chosen by Medicare. After the true out-of-pocket is reached, there is a 5% copay or coinsurance for the rest of the year.

You pay an annual deductible for some plans + **You pay 25% of your brand-name drug prescription cost until your true out-of-pocket is reached[a]** + **You have reached Catastrophic Coverage and you pay a 5% copay or coinsurance for the rest of the year**

When it comes time to select a Part D plan, there are many things to consider. You may think about

- Finding a plan that has the coverage for your relapsing MS medicines
- Yearly deductible costs
- Monthly premiums and copays

[a]This applies only to brand-name drugs. Your plan may have different copay for generic drugs.

How Can A Medigap Policy Help Pay for My Medicines?

Biogen

If you have Part A and Part B, you may want a Medigap policy. This is also called Medicare Supplemental Insurance. It can help pay for

- Copays and coinsurance for your relapsing MS treatments
- Copays and coinsurance for other medicines
- Coinsurance or deductible for visits to hospitals, neurologists, and other healthcare specialists

You must have Part A and Part B to get Medigap; you cannot get Medigap if you have Medicare Advantage (Part C). There are many types of Medigap policies. A Medigap policy charges a monthly premium, but costs vary and rise as you get older.

You can buy Medigap for 6 months after the month you turn age 65 and after having been enrolled in Part B. If you wait, you may not be able to get Medigap or it may cost more.

Some Medigap plans have out-of-pocket maximum limits. Be sure to ask if this applies to your Medigap plan or a Medigap plan you are considering.

For more information or to find Medigap policies in your area, call 1-800-633-4227 or go to www.medicare.gov.

Comparing Medicare Prescription Drug (Part D) Plans for Your Relapsing MS Care

Biogen

To understand the difference in total costs between 2 types of Part D plans, see the illustration for what you would have to pay if you had

- 12 months of premiums
- A deductible (some plans do not have a deductible)
- 4 prescription copays per month for 12 months, including 3 drugs to treat conditions other than your relapsing MS and 1 specialty drug to treat your relapsing MS (which likely has a high copay)[a]

Sample healthcare costs for Plan X and Plan Y

Note: These numbers are just examples. They are not meant to show actual plan coverage and costs. Contact your insurance plan for actual coverage costs.

The example of Plan X and Plan Y shows the following

- Plan X has a higher monthly premium ($45 per month) and no deductible
- Plan Y has a lower monthly premium ($17 per month) and a $445 deductible
- Patients in both plans pay 25% of costs in January; total cost for Plan X was $11,040 and for Plan Y was $10,220
- Patients in both plans reach Catastrophic Coverage in February and only pay 5% of their total costs
- The monthly copays are different

Over 1 year, Plan Y would cost you $426 less than Plan X. **That is why it is important to estimate the yearly costs for a deductible, premiums, and copays before selecting a plan.**

You can compare plan costs for your medicines at www.medicare.gov/find-a-plan.

[a]The example does not include an infused treatment for your relapsing MS that you may receive at a doctor's office. This treatment would be covered under Medicare Part B (medical insurance).

The Medicare Prescription Drug (Part D) Extra Help Benefit

Biogen

Extra Help is a benefit from the government that helps pay for Part D costs. You may be able to get Extra Help if you have low income or have limited assets (such as a checking or savings account, stocks, and bonds).

What can Extra Help do for me?

Extra Help can offer

$0 or a small initial deductible and monthly premiums

Lower out-of-pocket costs for brand-name prescriptions

The chance to change plans at any time. Any changes you make will take place on the first day of the next month

Do I qualify for Extra Help?

You may qualify for Extra Help if you are disabled or have low income. You will get Extra Help automatically with no need for paperwork if you

- Already have full Medicaid coverage ***(dual eligible)***
- Get help from Medicaid to pay for Part B
- Get Supplemental Security Income benefits

If you get Extra Help automatically, Medicare will mail you a purple letter. If you think you need Extra Help and have not received a purple letter, you can apply at any time by reaching out to Social Security (call 1-800-772-1213 or visit www.socialsecurity.gov/i1020).

What Are Medicare Savings Programs?

Biogen

Medicare Savings Programs are state programs that help you pay for

- Medicare premiums
- Part A and Part B deductibles
- Part A and Part B coinsurance
- Part A and Part B copays for your relapsing MS care

Depending on your income and resources, you may qualify for one of these programs

- Qualified Medicare Beneficiary Program
- Specified Low-Income Medicare Beneficiary Program
- Qualifying Individual Program
- Qualified Disabled and Working Individuals Program

How do I know if I qualify for a Medicare Savings Program?

- You must have or be eligible for Part A
- Your income must be below a certain limit
- Your resources (such as savings, stocks, and bonds) must be below a certain limit

Each Medicare Savings Program has different income and resource limits.

For information on the resource limits, go to www.medicare.gov and search "Medicare Savings Programs." Call your state Medicaid office to see if you qualify for a Medicare Savings Program.

What Should I Consider When Choosing a Medicare Plan?

Biogen

If you need more insurance than Part A and Part B provide, you have other options

Medicare Advantage (Part C) plan with drug coverage **OR** Medicare prescription drug (Part D) plan

Remember that you can add a Medigap policy for more coverage if you have Part A and Part B.

Be sure to look for a Part C plan or Part D plan with enough coverage for your relapsing MS treatment and care from your neurologist.

Before you choose a plan, talk with your doctor about your medical and prescription needs for next year.

- Will I have to change my relapsing MS medicine?
- Will I need additional services?

What Does it Mean To Be Dual Eligible?

You may be eligible for both Medicaid and Medicare. This is referred to as being “dual eligible.”

- If you qualify for both, Medicare is the primary payer. Medicaid then pays for all other eligible costs not covered by Medicare

What is Medicaid?

Biogen

Medicaid is a federal and state health insurance program. **Coverage includes**

Eligible, low-income adults

Eligible, low-income pregnant women

People with disabilities who qualify for Medicaid benefits

Eligible children

Eligible elderly

How Do I Know if I Qualify for Medicaid?

Each state has different eligibility requirements for Medicaid benefits. All states must meet certain federal eligibility requirements, but states also have the option to expand Medicaid beyond these minimum requirements.

Income eligibility requirements differ between states that have not expanded Medicaid. Contact your state Medicaid office if you have questions about specific income eligibility requirements in your state.

You can contact your state Medicaid office to learn more. To get the phone number for your state office, visit www.medicaid.gov or call 1-877-267-2323 and follow the prompts.

How Can I Apply for Medicaid?

Biogen

There are 3 ways to apply for Medicaid

Apply in person

Fill out an application at your nearest Medicaid office to apply for Medicaid through your state.

Apply by telephone

To find Medicaid contact information for your state visit www.medicaid.gov/about-us/contact-us/contact-your-state-questions/index.html.

Apply online

Fill out an application through the Health Insurance Marketplace at www.healthcare.gov. If you or someone in your household qualifies for Medicaid, your information will be sent to your state's Medicaid agency and you will be contacted.

What Documents Do I Need to Apply for Medicaid?

When you apply for Medicaid, you must provide information about yourself and your family. This may include

- Names and birthdates of your family members
- Social Security numbers of those applying for coverage
- Information about other health insurance you may have
- Information about work income and any other income

Be sure to review your application and/or provide documentation regarding

- Income
- Citizenship or immigration status
- Other health insurance, if applicable

What Does Medicaid Cover?

Medicaid covers 2 kinds of benefits

- Mandatory benefits required under federal law
- Optional benefits depending on the state in which you live

The table below lists all mandatory and most optional benefits. The benefits that may be helpful for people with relapsing MS are shown in **bold**. Check with your state Medicaid office to learn which optional benefits are covered in your state.

Mandatory Benefits	Optional Benefits
• **Inpatient hospital services**	• **Prescription drugs**
• **Outpatient hospital services (eg, infusion center)**	• **Clinic services**
• Early and periodic screening and diagnostic and treatment services	• **Physical therapy and occupational therapy**
• **Nursing facility services**	• Speech, hearing, and language disorder services
• **Home healthcare services**	• Respiratory care services
• **Physician services**	• **Other diagnostic, screening, preventive, and rehabilitative services**
• **Rural and federally qualified health center services**	• Optometry services, including eyeglasses
• **Laboratory and x-ray services**	• Podiatry services
• Family planning services	• Dental services, including dentures
• Nurse midwife services	• Chiropractic and other practitioner services
• **Certified nurse practitioner services**	• Prosthetics
• Freestanding birth center services	• **Private duty nursing services**
• **Transportation to medical care**	• **Personal care services**
• Tobacco-cessation counseling for pregnant women	• Hospice care
	• **Case management**
	• **Health home services for individuals with chronic conditions**

What Is A Medicaid Waiver?

States can expand Medicaid coverage by using ***Medicaid waiver*** programs. These programs offer some flexibility in which services the state covers. For instance, you may have access to certain healthcare services even if your income is too high to qualify for Medicaid.

One type of waiver program is the home and community-based services program. This program may allow you to get long-term care services at home or in a community-based setting. This keeps you from having to get these services in a nursing home or hospital. Standard services may include

- **Case management**
- **Homemaker services**
- **Home health aides**
- **Personal care services**
- **Adult medical day care**
- **Rehabilitation**

Centers for Medicare & Medicaid Services must approve these services for the state. Contact your state Medicaid office to learn more about these programs.

Another type of waiver program is the spousal impoverishment program. This is for a married person who is disabled and whose spouse is working and earning income. By waiving your spouse's income, you may be eligible for Medicaid.

What Will I Have to Pay?

Your state may require you to pay certain costs for Medicaid, including

- Copays
- Coinsurance
- Deductibles

What is the Difference Between Fee-for-Service and Managed Care Plans?

Your state may offer Medicaid benefits through fee-for-service plans, ***managed care plans***, or both. Coverage is different between fee-for-service plans and Managed Medicaid plans. It is important to understand what restrictions or limitations may apply to your medicine and other healthcare services.

Fee-for-Service

If you are in a fee-for-service plan, the state pays for each covered service that you receive in a hospital, provider clinic, and other healthcare setting.

Managed Medicaid

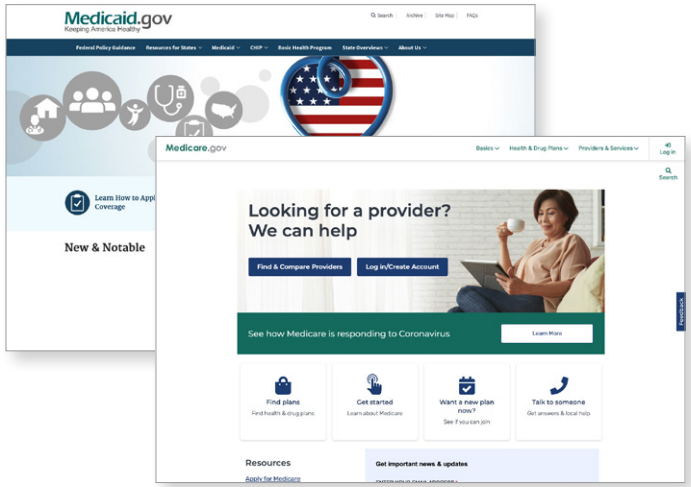
If you are in a managed care plan, the state pays a fee to the managed care plan for each person enrolled. The plan then pays your doctor for any service that is included in the plan's contract with the state.

Where Can I Learn More?

Biogen

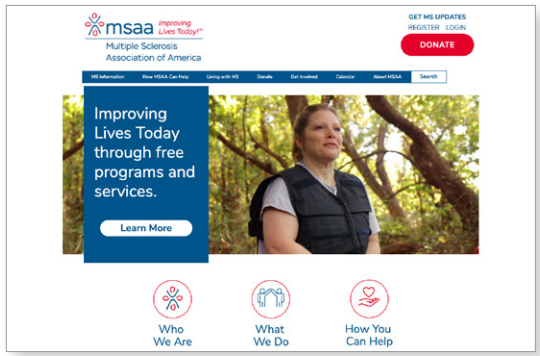
For more information, you can visit the following websites:

Centers for Medicare & Medicaid Services:
www.medicaid.gov and www.medicare.gov

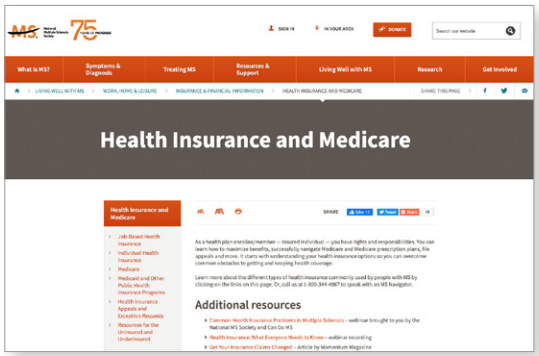


Social Security:
www.socialsecurity.gov

Multiple Sclerosis Association of America:
www.mymsaa.org (search "Medicaid," "Medicare," or "Insurance")



National Multiple Sclerosis Society:
https://www.nationalmssociety.org/Living-Well-With-MS/Work-and-Home/Insurance-and-Financial-Information/Health-Insurance



Biogen

Navigating Coverage and Access to Your Medications

How Your Health Plan's Medical Policy Affects Coverage

Biogen

Understanding How Medications Are Covered by Your Health Plan

A medical policy is a set of guidelines a health plan uses to assess if a medical service or drug is medically necessary and eligible for coverage. A plan may set certain limits on coverage based on a member's benefit, as defined within their contract. Health plans can review and update their policies, including a medical policy for treatments and services.

The coverage under each medical policy for treatments can vary from plan to plan.

Health plans may have criteria that must be met in order for a treatment to be covered.

Some patients may face coverage restrictions because of location. Their provider and/or the treatment center may be out of network or out of state.

Health plans may require a ***prior authorization*** renewal after a certain period. This is also called a reauthorization requirement.

What You Can Do

Review and understand your health plan's medical policy before starting a treatment for relapsing MS. Request that your health plan send you its medical policy for your treatment. You can do this by

- Calling the customer service phone number on your insurance ID card
- Checking your health plan's website
- Contacting your employer's human resources department if you are insured through an employer

The Approval Process for a Medication

Benefits Investigation

Once you are prescribed a medication, your doctor's office may research your plan's coverage. This is called a ***Benefits Investigation***. The Benefits Investigation helps you and your doctor's office understand

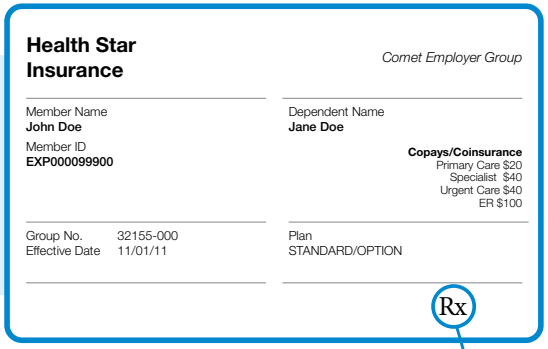
- Your current coverage
- Any steps and documents your insurer requires for an approval such as a prior authorization and a ***Letter of Medical Necessity***
- Coverage restrictions, such as the need for a referral (referral restriction) or out-of-state/out-of-network restrictions
- If you need to file a request for a ***medical exception***
- Your out-of-pocket costs, including deductibles, copayments, and coinsurance

If your health plan does not cover your treatment, a medical exception may be requested.

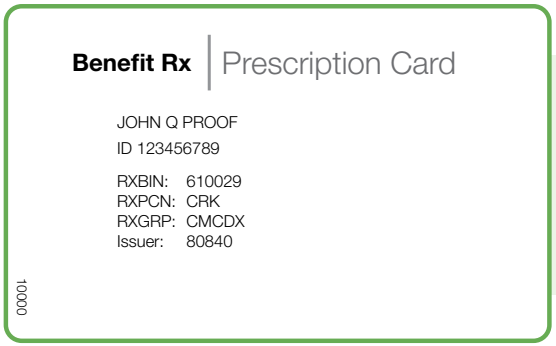
Biogen Support Services can also support you in this process. Learn more about **Biogen Support Services** on page 38.

Remember to provide your doctor's office with all insurance cards from your health plans.

Medical card for your office visit



If your medical card does not say "**Rx**," you may also have a second card similar to the one seen on the right.



Pharmacy card for your prescription

What Is a Prior Authorization?

In some cases, your health plan may need to approve your medicine before you can get it. This is known as a prior authorization, or PA. It may also be called a precertification.

Prior authorization requirements vary among health plans. Some plans have their own prior authorization form. Your doctor's office must complete and submit the form to the health plan along with any additional information requested. Documents and information that may be submitted include

- **Health plan ID numbers**
- **Test results**
- **Exam and lab results**
- **Patient notes and medical history**
- **Letter of Medical Necessity**

What You Can Do

Ask your doctor's office if it has all the information it needs to submit the prior authorization and if there is anything they need from you.

Medical Exceptions, Appeals, and Reauthorizations

Medical Exceptions

Sometimes a treatment is not covered by a health plan. However, it may still be prescribed if you and your doctor's office request a medical exception, or ME. Medical exception requests are usually more difficult than prior authorizations. They require more specific documentation, such as a Letter of Medical Necessity from your doctor's office.

There are many reasons why a medical exception may be denied. Fortunately, there are several steps you and your doctor's office can take to try to reverse your health plan's decision, such as an ***appeal***. You may also have the option to request an independent external review.

Appeals

If your health plan denies your prior authorization or medical exception request, you can appeal. This may mean that you and your doctor's office need to fill out paperwork and provide detailed documentation. You also need to communicate with your health plan(s).

Your coverage may be denied due to a billing, coding, or administrative error. If so, your doctor's office may be able to resolve the issue without a formal appeal.

If you cannot resolve the denial with your health plan, you may have the right to request an independent third-party review. This means your health plan will no longer have the final say about your benefits and coverage. Refer to the final denial letter sent to you by your health plan. This letter should tell you when you must make your request for an external review.

Speak with your health plan. You have the right to know why your request was denied. Your plan will most likely tell you in writing why your coverage was denied and how you can appeal.

Reauthorizations

Health plans may approve a treatment for a certain length of time or number of doses. Health plans may require a prior authorization renewal after a certain period of time. Reauthorization periods may vary among health plans. Speak with your doctor's office and/or your health plan to find out when a reauthorization will be required, and what else will need to be submitted.

Questions to Ask When Deciding Which Insurance Plan to Choose

Biogen

Do I qualify for the health plan I want to join?

When can I sign up for the health plan I want to join?

Is my current relapsing MS treatment covered?

Do I need a prior authorization for my Biogen treatment? Will it need to be reauthorized after initial approval?

If coverage is denied, what is the appeals process?

What happens if my doctor changes my prescription before the year is over? Will that affect my coverage?

Are other prescription drugs covered?

How much is the premium each year?

Is there a deductible? How much?

What are the copays and coinsurance for my doctor visits? For my medicines?

Once my deductible is met, how much will I pay for coinsurance?

Is my doctor in the plan's network? Will I be able to keep seeing the same doctor?

Will the service I need be in-network or out-of-network?

Will the health plan cover all my doctor visits?

Biogen

Biogen Support Services

Biogen Support Services

If you're living with relapsing MS, know that you're not alone. **Biogen Support Services** is here to help along the way. As soon as you're prescribed a Biogen treatment, we can provide help with financial assistance, navigating insurance, or learning more about your therapy. We're here to support you as you live with relapsing MS. Remember, your healthcare team is always your best source of information.

Biogen Support Coordinators

Once you're prescribed a Biogen treatment, you can get connected to a **Biogen Support Coordinator** who can help answer questions you may have. They'll provide one-on-one phone support and are ready to help you throughout treatment. **They'll help you access resources you may need, including**

- Helpful information throughout your time on a Biogen treatment
- Connections to financial and insurance assistance to help you access your medication
- In-person or online events where you can learn from experts and people living with relapsing MS
- Follow-up calls, if you're interested, to check in and see how you are doing

Get Support Today

Call a Biogen Support Coordinator at 1-800-456-2255, Monday-Friday from 8:30 AM to 8 PM ET.

Nurse Educators

Nurse Educators are registered nurses who work on behalf of Biogen, and many are MS-certified. They understand the challenges you may be facing and are ready to support you throughout your time on a Biogen treatment. They are available to

- Answer questions or provide information related to your relapsing MS and Biogen treatment

Although **Nurse Educators** can be a great resource for you, it's important to remember that your healthcare provider is always your best source of information.

Contact Nurse Educators at 1-800-456-2255.

Financial & Insurance Assistance

At Biogen, our goal is for everyone to get the support they need so they can afford their treatment. We can work with you to understand your insurance coverage and medication cost, and explore financial assistance options for your prescribed Biogen treatment.

Understanding Your Insurance

Biogen Support Coordinators will communicate with you and your insurance company to explain coverage options and costs, including guiding you through the Prior Authorization process. They can explain complicated insurance information and changes.

Finding Financial Assistance

Biogen Support Coordinators can also help identify potential options for financial assistance with your relapsing MS medication. If you are:

- Commercially insured: if you're eligible, the **Biogen Copay Program** could lower your medication cost to as little as $0[a]
- Government insured: we can check to see if you are eligible for alternative government insurance programs
- Uninsured or underinsured: we can research other possible financial assistance available to you

Get Support Today

Call 1-800-456-2255, Monday-Friday from 8:30 AM to 8 PM ET.

[a]There is an annual cap on the amount of assistance that patients can receive over a one-year period. Federal and state laws and other factors may prevent or otherwise restrict eligibility. People covered by Medicare, Medicaid, the VA/DoD, or any other federal plans are not eligible to enroll. You are eligible to enroll in the **Biogen Copay Program** for as long as it is offered and you are treated with a Biogen relapsing MS medication.

Glossary of Key Terms

Glossary of Key Terms

Appeal: A request for a health plan to reconsider its decision to deny coverage for a specific healthcare service or product.

Benefits Investigation: The research that is done to see if your health plan covers a specific medicine.

Coinsurance: A percentage of the total cost of care. Most plans require you to pay about 20% of total costs.

Consumer-driven health plan (CDHP): A health plan that lets you use HSAs or HRAs to pay directly for routine healthcare costs. To have a CDHP, you must be enrolled in an HDHP. These plans protect you from catastrophic medical expenses.

Copay (copayment): A fixed amount that you pay for healthcare visits or prescriptions. Usually, copays are $15 or $20. Your plan pays the remaining costs.

Deductible: A dollar amount that you must pay each year before your plan will provide coverage.

Dual eligible: A person who is eligible for both Medicaid and Medicare.

Fee-for-service (FFS): A method in which you and your health plan pay a portion of your costs at each visit or service. These plans give you more flexibility in choosing doctors or hospitals. But they tend to cost more. FFS is also known as indemnity insurance.

Flexible spending account (FSA): An account that you set up through your job to help pay for healthcare costs. You don't pay taxes on this money. But if you don't spend all of your FSA money by the end of year, you lose the money that is left.

Health Insurance Marketplace: A government-sponsored resource where you can choose a health plan. It also provides information on programs that offer financial help for insurance coverage.

Health maintenance organization (HMO): A type of plan in which you get care from a network of providers. Your primary care doctor coordinates all of your care.

Health savings account (HSA): An account you set up with your employer to save money for medical expenses. Like an FSA, you don't have to pay taxes on this money. Unlike an FSA, money can be carried over to the next year if you don't use it.

High-deductible health plan (HDHP): A healthcare plan with a higher deductible than a traditional healthcare plan. The monthly premium is usually lower, but you pay more healthcare costs yourself before the insurance company starts to pay its share (your deductible).

In-network: Doctors, hospitals, or other providers who participate in the health plan you choose. You usually pay less when using an in-network provider. Some plans only pay for services when the member uses in-network providers. Other plans will pay some of the cost even if the member uses an out-of-network provider.

Letter of Medical Necessity: A letter submitted by your doctor to your health plan that provides information to demonstrate that the requested healthcare services or supplies are needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, and meet accepted standards of care and the medical needs of the patient.

Managed care plan: Plans that include a network of doctors, hospitals, and other providers to coordinate care.

Medicaid: A federal and state health insurance program that provides healthcare coverage to adults, children, pregnant women, the elderly, and people with disabilities who qualify for Medicaid benefits.

Glossary of Key Terms (cont'd)

Medicaid waiver: An agreement between the federal government and states that allows states to be flexible in designing their Medicaid program.

Medical exception (ME): A medical exception is a request to use a drug due to the patient's individual situation, even though the drug is not covered by the patient's health plan.

Medicare: A government health insurance program that provides coverage for individuals aged 65 years or older and for those younger than 65 years who have certain disabilities.

Open Enrollment: A set period of time during which people can choose to make changes in their insurance coverage for the coming year.

Out-of-network: Doctors, hospitals, or other providers who are not part of the health insurance plan you choose. You will pay more for these services. Or you may need to pay out-of-pocket costs.

Out of pocket (OOP) and out-of-pocket maximum: The money you pay for your healthcare costs out of your own pocket. This amount is not paid back by your insurance company. The OOP maximum is the most you will have to pay during your policy period (usually 1 year). After you reach that limit, your insurance plan covers all the costs.

Point-of-service (POS) plan: A plan that coordinates care with a primary care doctor. It allows for more flexibility in choice of doctors and hospitals than an HMO.

Preferred provider organization (PPO): A plan that contracts doctors and hospitals to create a network of providers. You can get care outside of the network. But you'll pay less if you use in-network providers.

Premium: The amount paid for health insurance. This is usually paid every month.

Primary care physician (PCP): A physician (MD – Medical Doctor or DO – Doctor of Osteopathic Medicine) who provides or coordinates a range of healthcare services for a patient.

Prior authorization (PA): The requirement by a plan that, before coverage is allowed, a treatment or medication must be medically necessary.

Private (commercial) health insurance plan: Any health insurance plan that is not run by the federal or state government. Examples of private health insurance plans include employer-sponsored plans and health plans available through the Health Insurance Marketplace.

Public health insurance: Government-funded programs, such as Medicaid, Medicare, and the Health Insurance Marketplace. These programs provide coverage for people who are older, have certain disabilities, and/or have limited financial resources.

Specialty drug: High-cost drugs that treat serious, chronic diseases and require additional education from a healthcare professional. This can include drugs that are injected, infused, inhaled, or taken by mouth.