Understanding Healthcare Insurance Coverage

for STRENSIQ® (asfotase alfa)

A guide to covered benefits, the access approval process, and optional patient support services

STRENSIQ® (asfotase alfa) INDICATION & IMPORTANT SAFETY INFORMATION INCLUDING BOXED WARNING

INDICATION

What is STRENSIQ?
STRENSIQ is a prescription medicine used to treat people with perinatal, infantile, and juvenile onset hypophosphatasia (HPP).

IMPORTANT SAFETY INFORMATION

What is the most important information I should know about STRENSIQ?
STRENSIQ may cause serious side effects, including severe allergic (hypersensitivity) reactions. Allergic reactions are common with STRENSIQ treatment and can be severe and life-threatening. Severe allergic reactions have happened in some people within minutes after receiving STRENSIQ and more than 1 year after starting treatment with STRENSIQ. Stop using STRENSIQ and go to the nearest hospital emergency room right away if you or your loved one get any of the following signs and symptoms of a serious allergic reaction:

- difficulty breathing
- choking sensation
- swelling of your eyes, lips, or tongue
- dizziness
- nausea or vomiting
- fever
- headache
- sweating
- feeling irritable
- chills
- skin redness
- skin rash or hives
- itching or numbness of the tongue, lips, cheeks, or gums

Please see full Prescribing Information and Patient Information for STRENSIQ (asfotase alfa), including Boxed WARNING regarding severe allergic (hypersensitivity) reactions, and pages 1-2 for additional Important Safety Information.

Important Safety Information for STRENSIQ® (asfotase alfa) (cont'd)

What are the other possible side effects of STRENSIQ?
STRENSIQ may cause other serious side effects, including:

- **skin thickening or pits at the injection site (lipodystrophy).** Lipodystrophy is common and has happened after several months in people treated with STRENSIQ.
- **calcium build-up in the eyes and kidneys.** People with HPP are at increased risk for developing calcium build-up in the body. Calcium build-up in the eyes and kidneys has happened and is a common side effect of STRENSIQ. Calcium build-up in the eyes and kidneys may also happen in people with HPP who are not treated with STRENSIQ. Your healthcare provider should check your eyes and kidneys before and during treatment with STRENSIQ.
- **immune-related effects.** You may develop antibodies during treatment that may decrease how well STRENSIQ works. Tell your healthcare provider right away if you get worsening symptoms of HPP including: difficulty breathing, difficulty walking, feeling tired, bone pain, stiff joints, or loss of appetite.

The most common side effects of STRENSIQ include local skin injection site reactions such as skin redness, bruising, color change, pain, itching, hardening of the skin (induration), swelling, and bumps. These are not all the possible side effects of STRENSIQ. For more information, ask your healthcare provider or pharmacist. Call your healthcare provider for medical advice about side effects.

You will begin receiving STRENSIQ under the supervision of a healthcare provider. Tell your healthcare provider about all your medical conditions, including if you:

- have had an allergic reaction to STRENSIQ.
- are pregnant or plan to become pregnant. It is not known if STRENSIQ will harm your unborn baby.
- are breastfeeding or plan to breastfeed. It is not known if STRENSIQ passes into your breast milk. Talk to your healthcare provider about the best way to feed your baby if you use STRENSIQ.

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

There is a registry for people who use STRENSIQ. The purpose of this registry is to collect information about HPP and about what happens when you use STRENSIQ for a long time. For more information about this registry, talk with your healthcare provider or go to www.hppregistry.com

To report SUSPECTED SIDE EFFECTS, contact Alexion Pharmaceuticals, Inc. at 1-844-259-6783 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

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Understanding healthcare insurance

This guide is an educational resource to help patients and their caregivers understand health insurance coverage of STRENSIQ® (asfotase alfa). Being informed about the access process and the complimentary, personalized, patient support services available from Alexion's OneSource™ program can help you begin STRENSIQ treatment and continue without disruptions.

For the definitions of insurance terms used throughout this guide, please refer to the Glossary on page 32.

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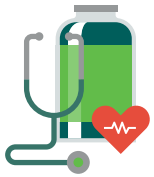
ONESOURCE®
Personalized Patient Support from Alexion

Questions? Our dedicated Case Managers are here to help!
888.765.4747 (M-F 8:30 AM – 8 PM ET)
OneSource@alexion.com

Please see full Prescribing Information and Patient Information for STRENSIQ (asfotase alfa), including Boxed WARNING regarding severe allergic (hypersensitivity) reactions, and pages 1-2 for additional Important Safety Information.

Medical and pharmacy benefits

Healthcare insurance helps you pay for medical services and medications. Most healthcare insurance policies include[2]:



Medical Benefits[3]

Cover physician and hospital services like visits to the doctor, medications, and some home health services. Medicines covered as a medical benefit include drugs that are administered in settings such as out-patient clinics and infusion centers.

Pharmacy Benefits[3]

Cover self-administered prescription medicines including oral, topical, and self-injectable ones—like STRENSIQ® (asfotase alfa)—that you can learn to use at home

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Types of healthcare insurance: private

Healthcare insurance is a benefit that helps you pay for medical services and medications. In the United States, there is a mix of public and private healthcare insurance.

Private (Commercial) Insurance

Group and Individual Health Insurance Plans[4,5,6]:

- Usually offered through your employer, but can also be purchased directly from a plan or through an insurance broker
- The monthly cost, or "premium," is typically shared by your employer and you
- There are many types of plans you can choose from during your annual enrollment period

Healthcare Insurance Marketplace Plans[4,6,7]:

- Offered to individuals, families, and small businesses in every state through "exchange" websites that allow you to purchase affordable plans directly from private healthcare insurance companies
- Monthly cost, or "premium," is paid by you (unless you qualify for a full or partial subsidy)
- You choose your marketplace insurance option during an annual enrollment period

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Types of healthcare insurance: private

Private healthcare insurance provides different types of plans designed to meet specific needs. Some plans restrict your provider choices to those within the plan's network. Others pay a greater share of costs for providers outside the plan's network.[8]

Plan type	Description	Can you go out of network?
Preferred provider organization (PPO)[8]	• Broad choice of network providers • Higher out of pocket costs • Less restrictive; referrals usually not required	Yes
Health maintenance organization (HMO)[8]	• Limits choice to doctors who work for or contract with the HMO • Referrals are generally required for specialists • May require you to live or work in its service area	No
Point of service (POS)[8]	• Mix of preferred provider organization (PPO) and health maintenance organization (MCO) • Lower cost if you use doctors, hospitals, and other healthcare providers that belong to the plan's network • Referral required to see a specialist	Yes, with referral from in-network doctor, and may pay more
Exclusive provider organization (EPO)[8]	• Items and services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency)	No, except in emergency
High deductible health plan (HDHP)[9]	• Lower premiums • Higher annual deductible • Higher out of pocket costs, depending on your healthcare needs	Depends on plan

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Types of healthcare insurance: public

Public (Government) Insurance

Medicare:

- Offered through the federal government to people aged ≥65 or <65 with certain permanent disabilities, eg, end-stage renal (kidney) disease and amyotrophic lateral sclerosis (ALS)[10]
- The monthly cost, or "premium," is $0 for inpatient hospital coverage[10]
- Premiums for coverage of drugs administered in an outpatient setting (Part B) or dispensed by a retail or mail order pharmacy (Part D) are paid by you (unless you qualify for a full or partial subsidy)[10-12]
- You can choose optional Part B and Part D coverage during an open enrollment period (some Part C plans include both Part B and Part D). STRENSIQ® (asfotase alfa) is covered under Medicare Part D.[10]

Medicaid:

- Offered through each state to people with low incomes and/or with certain disabilities[13]
- There is no monthly premium for medical services for enrollees with incomes below 150% of the federal poverty level, but there may be some cost-sharing in some states for certain drugs[14]
- Enrollment is ongoing throughout the year but there is typically an annual enrollment period to choose Managed Medicaid plans if offered in your state[10]

Department of Defense (DoD)/TRICARE, Veterans Health Administration (VHA)[15,16]:

- Offered through the federal government to provide health coverage for US military service members, veterans, and their families
- There may be annual enrollment fees and monthly premiums, based on plan types selected
- Enrollment is ongoing throughout the year for certain plans and there is an annual enrollment period for other plans

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Types of healthcare insurance: public

Medicare is a federal system of healthcare insurance for[10]:

- People over 65 years of age, or under age 65 with certain disabilities

Medicare has 4 parts

Part A[10]	Part B[10]	Part C (Medicare Advantage)[10]	Part D[10]
• Inpatient hospital stays • Skilled nursing facility stays • Hospice care • Home health services	• Doctor's office visits • Medications administered by your doctor • Other services like lab tests	• Combination of Parts A and B • Coverage comes from a private insurance company that contracts with the government • May also offer prescription drug coverage	• Covers prescription medicines (tablets, capsules, and other medicines you can take on your own) • Available to purchase if you have Part A and Part B
Out-of-pocket (OOP) cost: varies by length of stay	OOP cost: generally 20% of the cost of the service. You can also purchase a Medicare Supplement Insurance plan (**Medigap**) from a health plan, and it may help pay for this expense.	OOP cost: varies by plan	OOP cost can include • Deductible • Initial coverage phase • Donut hole or coverage gap • Catastrophic coverage

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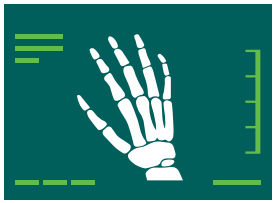
Types of healthcare insurance: public

Medicaid is a federal system of low-cost or free healthcare insurance[13]

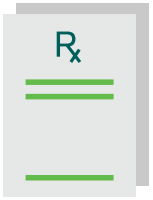
- Provides health coverage for eligible low-income adults, children, pregnant women, elderly adults, and people with certain disabilities[13]
- Coverage is determined individually by each state based on income requirements, the number of people in your household, family status, and other factors[13]

Medicaid can help cover medical costs by paying for items and services such as[13]:



- Hospital visits
- Home healthcare
- Doctor or nurse visits
- Medical tests
- X-rays, CAT scans, MRIs
- Transportation to medical care

Your state may also help pay for some other care, including[13]:



- Medications
- Occupational therapy
- Case management
- Medical equipment and procedures
- Physical therapy

Contact your state's Medicaid office for more information about eligibility guidelines at https://www.medicaid.gov/about-us/contact-us/index.html

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Have two types of insurance?

Some people may have two types of health insurance coverage. Your insurance plans will coordinate benefits between the two.

Primary Insurer/Payer pays first, up to a certain amount

Secondary Insurer/Payer pays the "cost gap," the amount not covered by the primary insurer

The Coordination of Benefits Form you receive from your healthcare plan will tell you which plan is your primary health plan and which one is secondary

It is your responsibility to notify each insurance company about the other. It is important that they are aware of one another to adequately manage your care.

People who have both Medicare and Medicaid insurance are known as "dual eligibles."[17]

FULL dual-eligibles receive[17]

- Benefits from Medicaid
- Assistance with premiums and cost-sharing for drug coverage from Medicare Part D

PARTIAL dual-eligibles[17]

- May have cost-sharing responsibility
- This is not the case for FULL dual-eligibles

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Healthcare insurance costs

You and your insurance plan share the cost of your healthcare.

Monthly premium

The amount you pay each month for coverage[18]

Out-of-pocket (OOP) costs

The costs you pay for healthcare that are not reimbursed, such as deductibles, coinsurance, and copays[19]

Deductible[20]

The amount you must pay before your insurance contributes to the cost.

Example: if your deductible is $300, you have to spend $300 before your insurance starts paying.

Copay/Co-insurance[21,22]

A fixed amount or percentage you pay each time you receive a specific service, procedure, or medication.

Co-pay: flat dollar value (example: $15 for a medication).

Co-insurance: percentage of the cost covered by your insurance (example: you pay 15% of the covered cost).

Your Out-of-Pocket (OOP) Maximum is the maximum amount of OOP expenses you will pay in a given year before your plan pays 100% for covered services. Private insurance companies are required to have an OOP maximum.[23]

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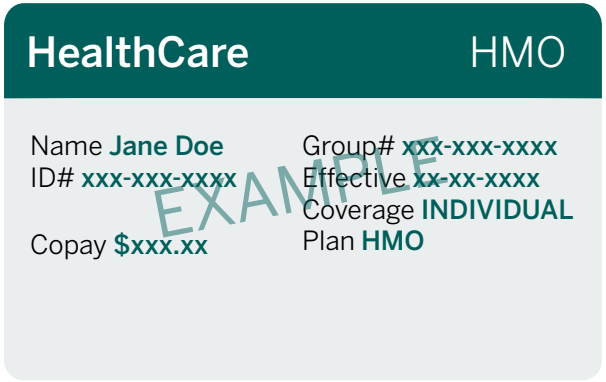
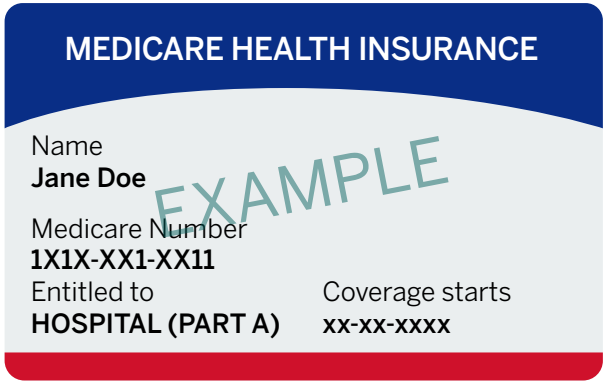
Healthcare insurance cards

Your insurance company will give you a health insurance card as proof of insurance. Doctors' offices use this information to process your healthcare claims. Some cards include the copay costs you may need to pay for different services or drugs.

Sample Private Healthcare Insurance Card



Sample Medicare Identification Card



Your doctor's office or care team may ask for your:

Member ID Number

This number is unique to you. It identifies you as an individual who is covered and allows you to access your benefits when you need care.

Group Number

If you received insurance through an employer, a group number will also be listed on your card. This helps identify the benefits you receive through your employer's plan. Your care team may use this number to file claims.

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Pharmacy benefit card

Some healthcare plans manage your medication coverage through a separate company called a **"pharmacy benefit manager," or PBM.** The PBM helps determine the cost of your medication and the requirements for your coverage.

If your medication is managed by a PBM, you may carry a separate insurance card specific to them. Other plans use the same card for both medical and prescription coverage.

Sample Pharmacy Card

Prescription Card Rx

Name **Jane Doe**
ID# **xxx-xxx-xxxx**

Copay **$xxx.xx**

Group# **xxx-xxx-xxxx**
Effective **xx-xx-xxxx**
Coverage **INDIVIDUAL**
Plan **HMO**

Rx **YES**
RXBIN **xxxxx**
RXPCN **xxxxxx**

EXAMPLE

Self-administered injectable medications like STRENSIQ® (asfotase alfa) are typically covered under the pharmacy benefit.

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Finding the right plan is a personal decision

Each healthcare plan has different medical and pharmacy benefits.

Doing research will help you ensure medical services and prescription drugs for your specific health needs are covered.

Some things to consider when evaluating your plan each year:

- ☐ What are my total annual costs? (look closely at the premium, deductible, copay, coinsurance, and other out-of-pocket [OOP] expenses)

  Tip: Plans with lower premiums will likely require you to pay higher deductibles, copayments, or coinsurance when you use medical services or purchase prescription medications. Examine the terms and OOP costs carefully; a policy with a low premium does not necessarily mean it is the least expensive in terms of your overall OOP costs for services and medications for a calendar year

- ☐ Are my preferred doctors, emergency care, and hospitals in-network?
- ☐ Are my medications covered?
- ☐ How restrictive are the coverage policies or prior authorization criteria for my medications among my plan options?

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Need help choosing a plan?

Make a Personal Connection

To ensure you understand your insurance coverage, contact the insurance company and work with a representative to help anticipate your costs.

They can help you with specific questions, like:

- Is your medication covered by the insurance plan?
- Does it require prior authorization?
- Does it require a copayment or coinsurance?

If you have Medicare, visit the "plan finder" to understand coverage and costs for prescription drugs at **https://www.medicare.gov/plan-compare**

Working with one consistent person at your insurance company may help get your questions answered and issues resolved. Keep their name and direct contact information handy!

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Getting coverage for STRENSIQ® (asfotase alfa)

Some insurance companies have certain processes to approve coverage for a specialty medication like STRENSIQ.

Benefits Verification

Your doctor's office will confirm your healthcare plan's coverage.

The benefits verification helps confirm the inclusion of STRENSIQ on your plan's drug formulary, your out-of-pocket (OOP) costs, and any other requirements from your plan, like:

- Referral
- Prior authorization
- Medical exception must be requested

Prior Authorization (PA)

Your insurance company uses this step to make sure the medication meets the plan's requirements before they cover it.

PAs are common for medicines like STRENSIQ that treat rare diseases, and may require information from your doctor such as:

- Medical history
- Results from lab tests or exams that confirm your diagnosis

Reauthorization

Your medication may need to be re-approved through your health plan after initial authorization.

If you require ongoing treatment that may continue beyond the initial period approved by your insurance company, a reauthorization may be required.

OneSource™ is a complimentary, personalized, patient support program offered by Alexion. OneSource can provide insurance coverage support to patients that have enrolled in the program.

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Approval time

Approval times can vary from plan to plan.

Your healthcare plan will review the information that your doctor's office submits to ensure it meets the coverage requirements.

There are a few things that affect the time it takes to complete the approval process:

- Benefits investigation with your insurance plan(s)
- Completing and submitting a prior authorization form, if required
- Gathering required information from your doctor's office that is requested by your insurance company

Here are some ways you can help:

- Get to know OneSource™, a complimentary, personalized, patient support program offered by Alexion
- Make sure your doctor's office and OneSource (if you are enrolled) have all your healthcare plan and treatment information
- Communicate promptly to your doctor's office and OneSource once someone from your plan contacts you about a decision

If your request for coverage is denied, you and your doctor's office may be able to **appeal the decision**.

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You have partners on your journey

Meet OneSource™ and PANTHERx Rare— here to help you every step of the way.

ONESOURCE®
Personalized Patient Support from Alexion

This complimentary, personalized patient support program offered by Alexion provides:

- Insurance coverage support (benefits verification, appeals, and more)
- Disease information
- Personalized, ongoing support
- Community connections

PANTHERx RARE

This specialty pharmacy dispenses STRENSIQ® (asfotase alfa) and provides:

- Help coordinating your prescription with your doctor
- Shipments and ongoing refills
- Instructions for self-administration
- 24/7 support

Get personalized support from OneSource
Call: **1.888.765.4747**
Email: **OneSource@alexion.com**
Visit: **AlexionOneSource.com**

To contact PANTHERx Rare Pharmacy:
Call: **1.844.787.6747**
Email: **strensiq@pantherxrare.com**
Visit: : **Pantherxrare.com**

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Your STRENSIQ® (asfotase alfa) treatment journey

Journey from prescription to treatment with STRENSIQ® (asfotase alfa).

Prescription submitted by doctor; OneSource™ enrollment submitted by doctor or patient

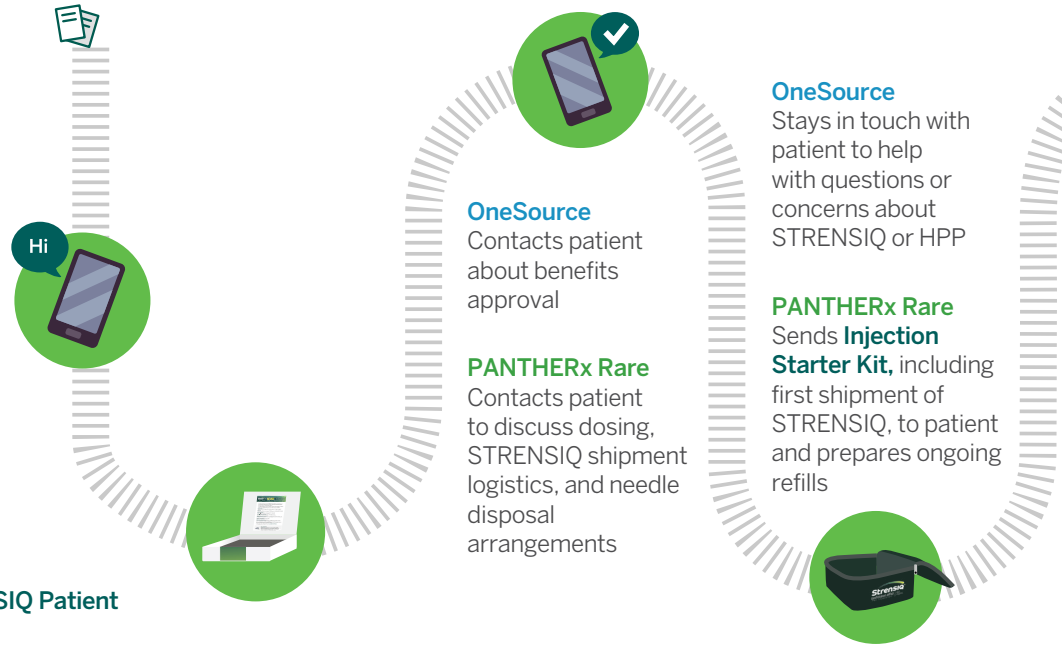
OneSource
Patient opts to enroll into OneSource patient support services and receives a welcome call

PANTHERx Rare
Manages patient's prescription with their doctor

OneSource
Patient receives the **STRENSIQ Patient Starter Kit** from OneSource

PANTHERx Rare works together with patient's insurance to verify benefits, assist with prior authorization and appeals, and explore affordability options *

**If patient faces any challenges throughout the appeal process, OneSource can help*



OneSource
Contacts patient about benefits approval

PANTHERx Rare
Contacts patient to discuss dosing, STRENSIQ shipment logistics, and needle disposal arrangements

OneSource
Stays in touch with patient to help with questions or concerns about STRENSIQ or HPP

PANTHERx Rare
Sends **Injection Starter Kit,** including first shipment of STRENSIQ, to patient and prepares ongoing refills

OneSource
Will provide injection support, including injection tips and resources, throughout treatment

PANTHERx Rare
Will coordinate an FDA-cleared sharps disposal container delivery for use after injections

Periodic insurance reauthorizations require patient to visit their doctor for an exam and lab testing to show STRENSIQ is providing clinical benefit

As patient continues treatment with STRENSIQ, **OneSource** and **PANTHERx Rare** can provide educational resources and tools

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Paying for your treatment

Your insurance for prescription medications may require a copay or coinsurance when you receive STRENSIQ® (asfotase alfa).

Insurance type	OOP Expenses	OOP Maximums
Private insurance[24]	Deductibles and your copayment/coinsurance will vary by insurance plan.[24]	Your private insurance plan will have an OOP maximum for a plan year.[24]
Medicare Part D[25]	Typically has a deductible before coverage begins[25] • Initial coverage phase: you pay 25% of the cost up to a certain amount (varies by year) • Donut hole phase: you pay 25% of the cost up to another amount (varies by year) • Catastrophic coverage: you pay less than $10 for brand-name and generic medications, or 5% of retail costs, whichever is higher	There is no OOP maximum. Catastrophic coverage entitles you to significant cost savings for the calendar year and you may reach this level on the first fill of a specialty medicine like STRENSIQ.[25]
Medicaid[26]	Some states have deductibles, copayments, and coinsurance on most Medicaid-covered benefits. The amount charged varies by income.[26]	Cost sharing for most services and drugs is limited to minimal amounts. These amounts are updated annually to account for increasing costs.[26]
DoD/ TRICARE, VHA[15,16]	**DoD/TRICARE:** For active-duty service members: no prescription drug costs when using a military or TRICARE pharmacy.[15] For family members and retirees, deductibles and copayments vary based on plan, medications, and which pharmacy is used.[15] **VHA:** Copays (starting at $0) vary based on priority group.[16]	DoD/TRICARE: Varies by sponsor or beneficiary type and group.[15] VHA: Varies (starting at $0) based on priority group.[16]

Concerned about costs? Learn more about cost savings.

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Understanding the Statement of Benefits

After treatment, your healthcare plan will send you a record of the items and services you received. These statements have various names, depending on the plan.

Explanation of Benefits (EOB)

Summary of Benefits (SOB)

Medicare Summary Notice (MSN)

These statements are not bills. They tell you:

- How much your treatment or care costs
- How much your plan will pay toward those costs
- How much you may need to pay
- If items and services aren't covered by your health plan

Many factors can affect how much you pay for your treatment, such as:

- How and where treatment is given
- Plan deductible
- Copay amount/co-insurance rate
- Cost of medication

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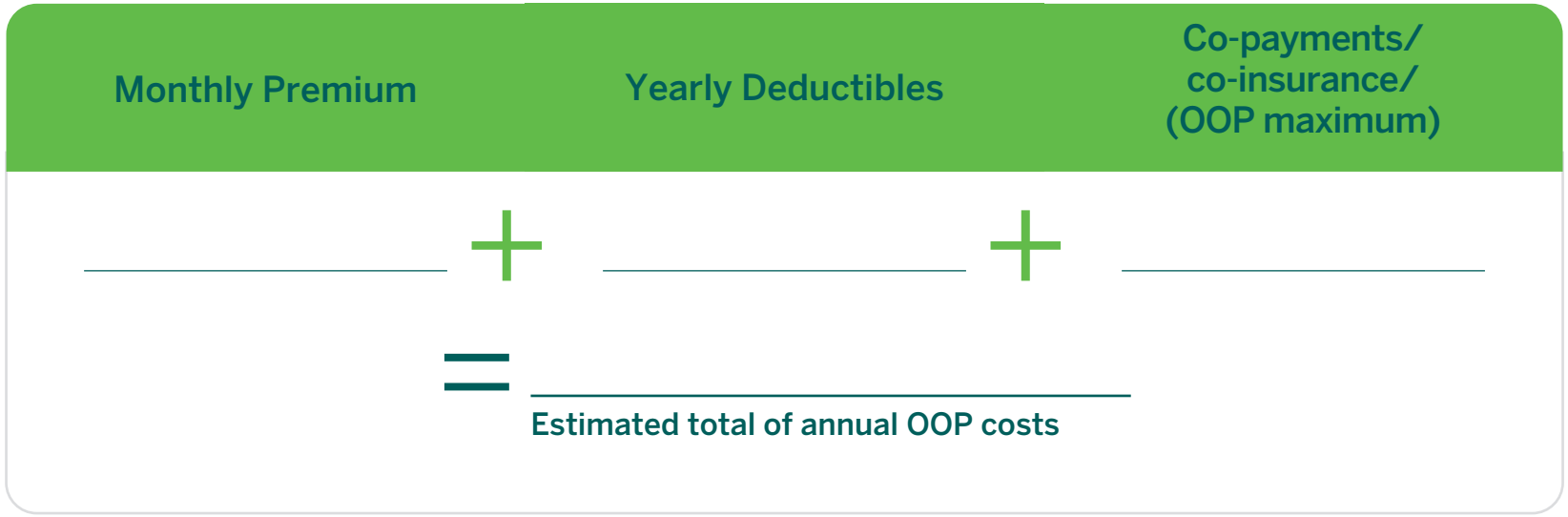
Calculate the cost of your coverage

It may help to keep a record of your out-of-pocket (OOP) costs. You can find this information on your EOB, SOB, or MSN.



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Concerned about costs?

ALEXION OneSource™ Copay Program

If you have private healthcare insurance, OneSource may be able to help.

ONESOURCE®
Personalized Patient Support from Alexion

Privately insured

The Alexion OneSource CoPay Program helps patients with private insurance pay for eligible out-of-pocket medication costs.

All others

The Program is not valid for costs eligible to be reimbursed, in whole or in part, by government insurance programs, including Medicaid, Medicare (including Medicare Part D), Medicare Advantage Plans, Medigap, Veterans Affairs, Department of Defense or TRICARE, or other federal or state programs (including any state prescription drug assistance programs).

Program eligibility:

- Patients enrolled in OneSource
- Patients with private insurance who have a valid prescription for a US Food and Drug Administration–approved indication for STRENSIQ® (asfotase alfa)
- Patients must reside and receive treatment with a Qualifying Alexion Product in the United States or its territories

Contact OneSource

- Call: **1.888.765.4747**
- Email: **OneSource@alexion.com**
- Visit: **AlexionOneSource.com**

You may be asked to provide information from your pharmacy benefit card when applying for the Alexion OneSource CoPay Program.

Reminder: For the definition of insurance terms used throughout this guide, please refer to the Glossary on page 32.

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Concerned about costs? (cont'd)

Independent foundations: OneSource™ can connect you with independent foundations that may be able to assist with out-of-pocket (OOP) costs like copays, transportation, and premiums.

OneSource can only refer patients to independent third-party foundations that may be able to help with the patient's OOP costs. The foundations make their own determinations about what (if any) assistance they will provide.

Eligibility requirements can be found directly on the foundations' websites. Alexion does not endorse or guarantee reimbursement or support from the organizations listed below.

NORD®
National Organization for Rare Disorders

Visit: rarediseases.org
Call: 203-202-8833

The Assistance Fund

Visit: tafcares.org
Call: 1-855-845-3663

Independent foundations may ask you to provide financial information if you apply for patient support funds.

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Concerned about costs? (cont'd)

If you have **Medicare,** there are programs to help.

Medigap

If you have Medicare Parts A and B, you can purchase Medigap from a healthcare plan to help pay for costs like copayments and coinsurance

Medicare Extra Help

If you have Medicare Part D, Extra Help provides full or partial help for prescription costs like premiums, deductibles, and coinsurance

Visit **https://www.medicare.gov/basics/costs/help/drug-costs https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap** for more information

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Unplanned interruption?

Interruptions in coverage can happen. Alexion OneSource™ provides supportive resources to help you and your doctor if issues arise.

If your insurance changes for any reason (for example, you start a new job, your employer changes its insurance company, you join a spouse's plan, or you become eligible for Medicare), let your doctor's office staff know right away. They can help with:

- Understanding your new benefits
- Submitting any prior authorization materials to the new insurance company

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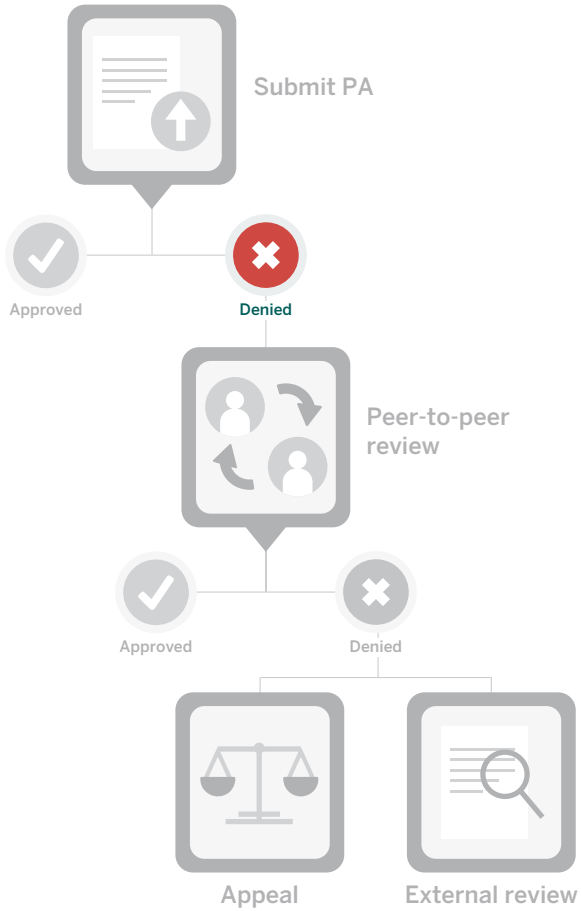
Prior authorization denials and appeals

If you receive a prior authorization (PA) or medical exception (ME) denial for STRENSIQ® (asfotase alfa), you may still be able to get coverage approved.

Contact your doctor's office and OneSource™ (if enrolled) right away for assistance.

Review the reason(s) for the denial provided by your insurance company

Give your denial letter and summary of benefits to your doctor to review the reason(s) for denial and determine next steps to help get the PA approved.



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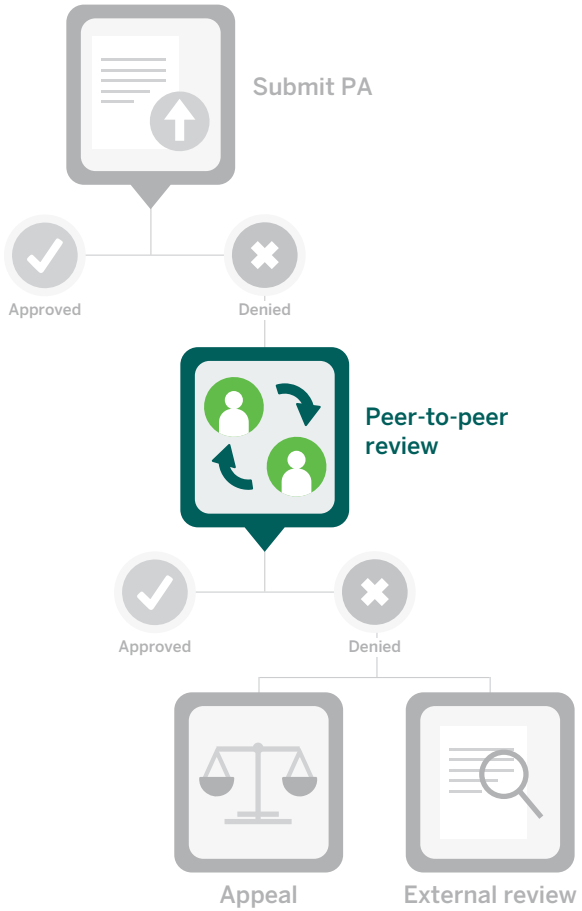
Prior authorization denials and appeals (cont'd)

If the PA/ME is still denied after reconsideration, ask your doctor to consider a peer-to-peer review

- If the reason for denial is misalignment with the clinical policy, your doctor may consider a peer-to-peer (doctor-to-doctor) review with a medical director at your healthcare insurance company
- You can work with your doctor to decide if this is the appropriate course of action
- If the peer-to-peer discussion does not resolve the denial, your doctor may submit an appeal



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Prior authorization denials and appeals (cont'd)

Appeal preparation and submission process

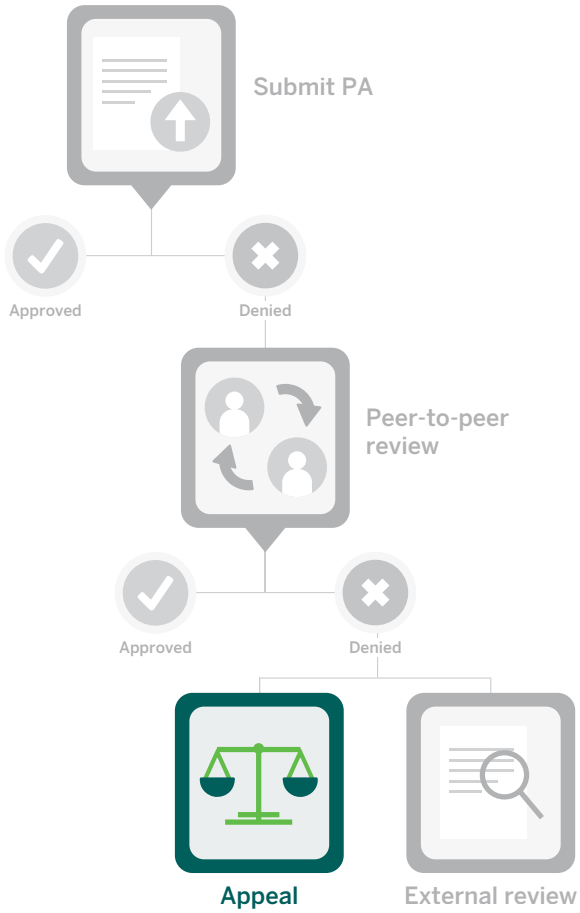
You and your doctor may decide to submit an appeal to your insurance company to reverse its decision. Your doctor will review the company's appeal process and timelines to determine:

- The specific form to be filled out for an appeal
- The company's preferred method of appeal (phone or written)
- Which documentation (appeal letter, original claim, etc) should be included
- Determine if an expedited review is available and appropriate for your situation

Follow up

Your doctor should follow up with the healthcare insurance company to confirm that the appeal was received and to check on a decision.

Your doctor should complete the required documents and submit the appeal as per the instructions of the insurance company. Keep in mind, the appeal process may take several weeks, unless an expedited review was requested, which must be completed by the insurance company within 72 hours.[27]



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Understanding Insurance | Optimizing Your Coverage | Verifying Your Benefits | Approval Process | Glossary

Prior authorization denials and appeals (cont'd)

External review

- If the internal appeals process was not successful, you or your physician can ask for an external review by independent, accredited medical professionals
- The insurance company's original denial letter should describe how to request an external review
- To request an external review, you or your physician must file a written request within the insurance company's specified timeframe. External review decisions are made as soon as possible, but generally take no longer than 60 days from receipt of request

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Patient support for access processes and managing your HPP

ONESOURCE®
Personalized Patient Support from Alexion

OneSource™ is a complimentary, personalized patient support program offered by Alexion. It features a dedicated team of OneSource professionals with expertise in rare disorders and the health care system.

Health insurance navigation

Community connections

Disease information

Copay assistance*

Ongoing support

*For eligible patients. Government-insured patients are not eligible for CoPay assistance.

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Glossary of Terms

C

Catastrophic Coverage: Catastrophic coverage is a phase of coverage designed to protect you from having to pay very high out-of-pocket costs for prescription drugs. It usually begins after you have spent a pre-determined amount on your health care.

Coinsurance: A fixed percentage of the cost of all services and prescription drugs a policyholder is required to pay. The coinsurance for certain services or prescription drugs may vary.

Coordination of Benefits: When a patient has more than one healthcare plan, a coordination of benefits policy decides which plan pays first. The health plan that pays first is the primary payer or primary insurer, which will likely pay up to a certain amount. The plan that pays the cost not covered by the primary payer (also called the cost gap) is the secondary payer or secondary insurer.

Copayment: A copayment is a fixed dollar amount a policyholder pays for a specific service, procedure, or drug each time he or she receives care or fills a prescription.

D

Deductible: The out-of-pocket (OOP) expenses a patient must pay before the payer begins paying for healthcare expenses.

Department of Defense (DoD)/TRICARE: Healthcare insurance plans offered through the federal government to active-duty US military service members, veterans, and their families.

Donut Hole: Also known as "Coverage Gap." The phase of Medicare Part D coverage after your initial coverage period. As a result of the Affordable Care Act (ACA), the coverage gap was phased out in 2020. Your drug costs may still change when you enter the coverage gap, after your initial coverage period, but you will pay no more than 25% of the cost of your drugs in the coverage gap.

Dual Eligibles: People who receive assistance from both Medicare and Medicaid are known as "dual eligibles." Dual eligibles may receive Medicaid benefits plus premium and cost-sharing assistance for drug coverage under Medicare Part D.

E

Exclusive Provider Organization (EPO): A managed care plan where services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency).

Glossary of Terms (cont'd)

f **Formulary:** A list of covered drugs under the pharmacy benefit by a healthcare plan. A formulary is organized by tiers, which are generally differentiated by the cost-sharing requirement for the patient.

g **Group Health Insurance:** Is a type of insurance offered through someone's employer. The cost for the monthly premium is generally shared between the employer and employee. There may be an annual enrollment period to select among several healthcare insurance plan options.

h **Health Maintenance Organization (HMO):** A type of healthcare insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. Referrals are generally required for specialists. HMOs also generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage.

High Deductible Health Plan: A plan with a higher deductible than a traditional insurance 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).

i **Individual Health Insurance Plans:** Is a type of health insurance offered directly from a private healthcare insurance company. Generally, an individual is likely to shop for and purchase an individual plan through an online website for the marketplaces, like healthcare.gov. The enrollment period for the marketplaces is from November 1 to December 15. While an individual will have to pay the entire monthly premium for an individual plan, they may have access to a subsidy to pay for a portion of the monthly premium.

Initial Coverage Phase: The 3 months immediately before you are entitled to Medicare Part A and enrolled in Part B. You may choose a Medicare healthcare plan during your Initial Coverage Phase. The plan must accept you unless it has reached its limit in the number of members.

Glossary of Terms (cont'd)

m

Medicaid: is a type of government insurance that provides low-cost or free health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. Each state has different requirements for income, the number of people in your household, family status, and other factors.

Medical Benefit: The medical benefit typically covers physician and hospital services for things like visits to the doctor, drugs administered by doctors, hospital services and supplies, and some home health services.

Medical Exception: This is a special request for treatment that requires additional paperwork from your doctor's office. Medical exception requests are usually more complex than prior authorizations and may require more specific documentation such as a Letter of Medical Necessity from your doctor's office. Some states have laws that require healthcare plans to respond to a medical exception request within a certain time period.

Medicare: Medicare is a federal system of health insurance for people over 65 years of age, people under age 65 with certain disabilities, and people of any age with end-stage renal (kidney) disease or amyotrophic lateral sclerosis (ALS).

Medicare Extra Help: Program administered by the Social Security Administration that helps pay for Medicare Part D premiums and drug costs for eligible individuals.

o

Out-of-Pocket (OOP): Out-of-pocket (OOP) costs typically include a beneficiary's premium, coinsurance or copay, and deductible. There may also be other OOP costs such as a non-covered product or procedure.

p

Pharmacy Benefit: The pharmacy benefit typically covers prescription drugs taken orally and self-administered injectable prescription drugs that are used at home.

Point of Service (POS): A type of plan where you pay less if you use doctors, hospitals, and other healthcare providers that belong to the plan's network. A hybrid of PPOs and HMOs, POS plans require you to get a referral from your primary care doctor in order to see a specialist.

Glossary of Terms (cont'd)

Preferred Provider Organization (PPO): Features a broad choice of network providers with the ability to go out of network for a higher out-of-pocket (OOP) cost. A popular plan type, PPOs are less restrictive than other types like HMOs as referrals to providers are usually not required.

Premium: The premium is the monthly fee a policyholder pays for coverage. Policies with lower premiums will likely require policyholders to pay more in the form of deductibles and copayments when they make use of medical services.

Prior Authorization: Requirement for prescribers or patients to receive approval for access to a covered product, typically based on cost or ensuring that patients meet clinical criteria appropriate for treatment with the product. Prior authorization is often referred to as a PA.

Private Healthcare Insurance: A type of health insurance plan funded by a private healthcare insurer and not provided by the federal or state governments. Generally, an individual may access private health insurance through their employer (or union) or directly from a healthcare insurance company. Private health insurance may also be referred to as "commercial insurance."

Public (Government) Insurance: A type of health insurance offered and managed by the federal or state governments. The two primary examples of public healthcare insurance are Medicare and Medicaid.

r

Reauthorization: The process of getting a medication re-approved through your health plan after initial authorization. Insurance companies may approve a medication for a certain length of time or number of doses, depending on your coverage. If a disease requires ongoing treatment that may continue beyond the initial period approved by your insurance company, a reauthorization may be required.

t

TRICARE: Healthcare insurance plans offered through the federal government to active-duty US military service members, veterans, and their families.

V

Veterans Health Administration (VHA): Healthcare insurance plans offered through the federal government to US military veterans and their families

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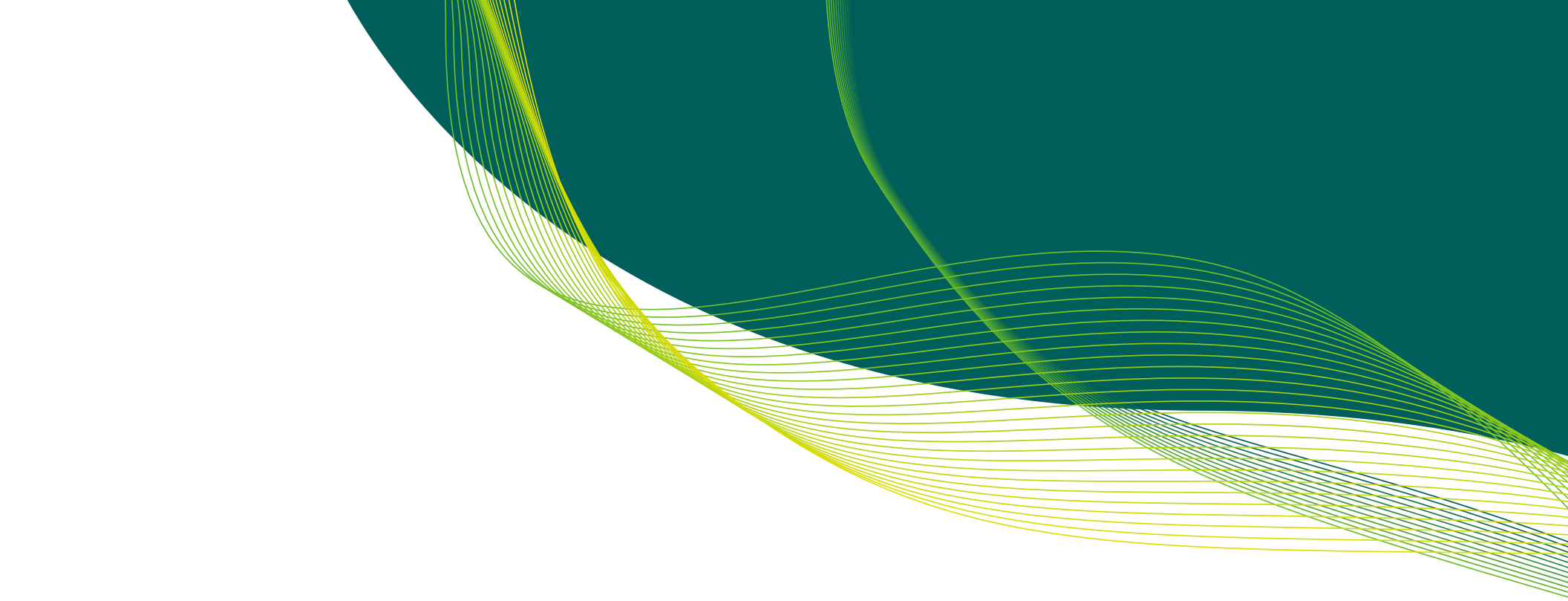

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