Health Insurance 101:
Understanding Your Options

Health insurance is complicated.

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

This guide will assist you in:

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

Throughout this guide, you will come across key terms **underlined in blue**. These words are defined in the glossary beginning on page 11.

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

Exploring the Types of Health Insurance Plans

There are 2 main types of health insurance plans: Commercial and government-funded.

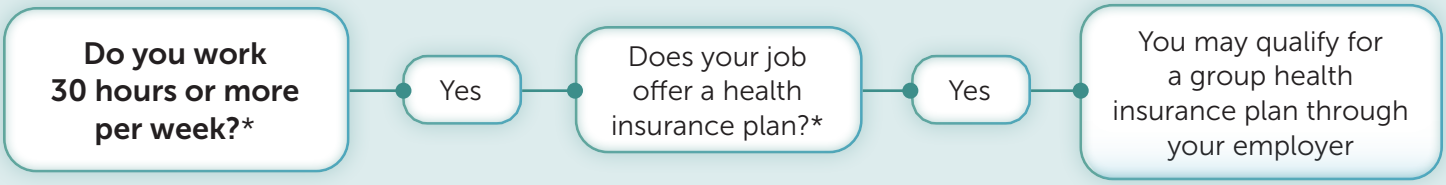
Review the information below to find the plan that may suit you best.

Commercial Health Insurance Plans

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

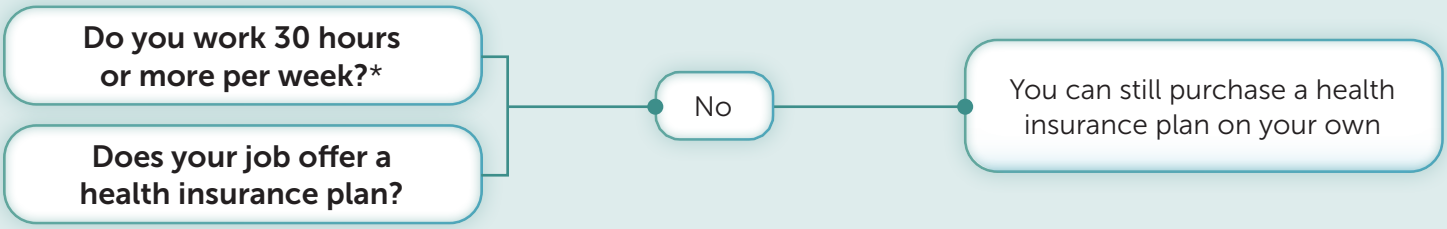
There are different types of commercial health insurance plans, such as HMO, PPO, and HDHP. To learn more, reach out to your myAgios® Patient Support Manager.

Group plans



Group health insurance is often offered through an employer. Usually, the employee and the employer both contribute to the premium.

Individual plans



Individual health insurance can be purchased by you or your family directly from a private, non-government insurer, or through the Health Insurance Marketplace (also known as the Health Insurance Exchange).

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

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

Agios offers myAgios® Patient Support Services for patients taking Agios medicines and their caregivers. It is not an insurance program. For more information, go to page 10 and/or call a Patient Support Manager to learn more at **1-877-77-AGIOS (1-877-772-4467)**, Mon-Fri, 8 AM to 8 PM, ET.

Government-Funded Health Insurance Plans

Are you age 65 or older or disabled?

Do you have limited income?

Yes

You may qualify for Medicare or Medicaid

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

Medicare

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

Medicare is a government-funded health insurance plan for people aged 65 or older and younger people who have certain disabilities (eg, end-stage renal disease [ESRD] or ALS [also called Lou Gehrig's disease]).

For those eligible, enrolling in Medicare includes Parts A and B. Medicare also offers other options that can cover your medicines, but you will need to enroll in them separately for this type of coverage.

Medicare options for medicine coverage:

Part C: Medicare Advantage

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

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

Part D: Drug Coverage

Helps cover the cost of prescription medicines.

Also known as Medicare Prescription Drug Plan (PDP).

Part D: Extra Help

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

To apply for the Extra Help program, click **here**.

Starting in 2025, there is an annual maximum out-of-pocket for Part D prescription drugs. Contact a Patient Support Manager to learn more.

ALS, amyotrophic lateral sclerosis.

myAgios® is here to support you in your unique journey. Get your insurance questions answered by calling a Patient Support Manager at **1-877-77-AGIOS (1-877-772-4467)**, Mon-Fri, 8 AM to 8 PM, ET.

Government-Funded Health Insurance Plans

(continued)

Medicaid

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

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

Medicaid covers:

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

Each state can have different eligibility criteria for Medicaid.

Dual eligibility

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

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

Some benefits include:

- For medicine costs, you will be automatically enrolled in a Medicare Prescription Drug Plan. Medicare will cover the cost of your medicines instead of Medicaid, meaning you will never pay 100% of the cost for medicines covered by Medicare
- For medical and hospitalization costs, Medicare will cover the costs first and then Medicaid will pay the remaining cost for care
- Medicaid may also cover long-term care services at home or in your community

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

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Choosing a Health Insurance Plan

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

Things to know:

Check what is covered on the plan

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

Example questions to ask when you call each health insurance plan:

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

Find out how much you will pay for services

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

Understand programs that can affect your medicine costs

Some commercial health insurance plans use copay accumulator or copay maximizer programs. These types of programs can prevent you from using manufacturer copay assistance to help meet your out-of-pocket costs, including your out-of-pocket maximums.

See page 6 to learn more about these copay adjustment programs.

If your insurance policy changes, contact your myAgios® Patient Support Manager. A Patient Support Manager is also available to discuss financial assistance options. Get your questions answered by calling your Patient Support Manager at **1-877-77-AGIOS (1-877-772-4467)**, Mon-Fri, 8 AM to 8 PM, ET.

See page 7 for the Comparing Health Insurance Plans worksheet to help you decide between health insurance plans.

Understand programs that can affect your medicine costs (continued)

Here are two examples of copay adjustment programs:

Copay accumulator programs*

A health insurance plan notes when manufacturer copay assistance is used to help pay the deductible, copay, and coinsurance for your medicines.

→ This payment amount is excluded from counting toward your out-of-pocket costs.

Once the manufacturer copay assistance is exhausted, you may have to pay your deductible and copays or coinsurance for your medicines. Copay accumulator programs are banned in some states, but these bans typically only apply to certain types of health insurance plans.

Copay maximizer programs*

A health insurance plan uses the maximum amount of manufacturer copay assistance available for your medicines.

→ This payment amount is excluded from counting toward your maximum out-of-pocket costs.

The health insurance plans may use copay maximizer programs to require you to enroll with a third party for certain medicines. The third party may in turn be able to adjust your monthly copay to a higher amount, thereby resulting in a greater cost burden for you than otherwise would have been required.

*These programs are applied only to commercial health insurance plans.

Contact your myAgios® Patient Support Manager if you have any additional questions about this information. Get your questions answered by calling your Patient Support Manager at **1-877-77-AGIOS (1-877-772-4467)**, Mon-Fri, 8 AM to 8 PM, ET.

Comparing Health Insurance Plans

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

Insurance Plan A		Insurance Plan B	

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

MY CURRENT HEALTHCARE PROVIDERS		PLAN A		PLAN B	
Healthcare provider	Name of doctor	Covered (Y/N)	Copay/coinsurance ($ or % per visit)	Covered (Y/N)	Copay/coinsurance ($ or % per visit)
Primary care					
Hematologist					

MY MEDICINES	PRESCRIPTION DRUG PLAN A			PRESCRIPTION DRUG PLAN B		
Medicine name	Covered (Y/N)	Copay/coinsurance ($ or % per fill)	PA required (Y/N)	Covered (Y/N)	Copay/coinsurance ($ or % per fill)	PA required (Y/N)

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

PA, prior authorization.

Navigating Health Insurance Changes and Drug Coverage

What to do after you change your plan:

- [ ] **Update your healthcare team.**
You will need to let your doctor and members of your healthcare team know your health insurance plan has changed. They may need your:
  - **Member ID number** – This number is just for you and identifies you as a covered member. You need your member ID number to access benefits
  - **Group number** – Depending on your plan, a group number could be listed on your card. This helps identify the benefits you receive. Your healthcare providers may need this number to file a claim for you

- [ ] **Update your Patient Support Manager.**
By providing your latest insurance information, a Patient Support Manager will address any questions, provide helpful resources, and notify your provider. When your plan changes, call a Patient Support Manager at **1-877-772-4467**, Mon-Fri, 8 AM to 8 PM, ET.

- [ ] **Inform your pharmacy.**
You should let your pharmacy know about your insurance change as soon as possible in order to avoid delays in receiving your medicines. You may have 2 separate insurance cards: One to use at a hospital or doctor's office and a second one to use at the pharmacy.

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

Loss of employer-based coverage

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

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

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

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

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

myAgios® is here to support you with changes in insurance coverage, loss of insurance, and other financial support in your unique journey. Get your insurance questions answered by calling your Patient Support Manager at **1-877-77-AGIOS (1-877-772-4467)**, Mon-Fri, 8 AM to 8 PM, ET.

The Drug Coverage Process

Benefits investigation

After writing a prescription, your doctor's office may conduct a benefits investigation to determine if your health insurance plan covers your medicine. You can find additional support for benefits investigation and coverage questions through myAgios®.

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

A PA and an ME are types of requests that the health insurance plan can make before treatment starts. Health insurance companies may require a PA for high-cost medicines or medicines that are used to treat complex health conditions. The doctor's office will complete the necessary paperwork.

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

Receive treatment with the prescribed medicine

If there is an approval and the prescription is covered, you receive the medicine. Typically, approvals are good for 6 to 12 months, after which they would need to be re-approved by your health insurance plan.

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

How to Request an Appeal

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

Level 1

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

Level 2

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

Level 3

- If the appeal is still denied by the health insurance plan, you may have the right to ask for an independent third-party review
- This means the health plan will no longer have the final say regarding coverage and is required by law to accept the external reviewer's decision

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myAgios® Patient Support Services

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

Whether you're considering treatment, ready to start, or looking for more information, myAgios is here to help you.

myAgios is a customized support program designed to provide personalized education and treatment support.

The dedicated team at myAgios is made up of **Agios Clinical Educators (ACEs)**, who deliver personalized education, and **Patient Support Managers (PSMs)**, who provide customized treatment support.

myAgios offers help with:

- **Disease education and support** in understanding treatment options
- **Accessing PYRUKYND® (mitapivat)** and understanding insurance coverage
- Exploring ways to **make PYRUKYND more affordable**
- **Ongoing treatment support** for people who have been prescribed PYRUKYND
- **Resources** for living with your condition

For one-on-one disease and treatment education, connect with an Agios Clinical Educator near you.
Visit **myAgios.com/ace-locator** or call **1-877-77-AGIOS** (**1-877-772-4467**).

ACEs and PSMs do not provide medical advice.
For medical advice or treatment-related questions, please talk to your healthcare team.

Glossary of Key Insurance Terms

Below are important terms seen in this guide. Contact your Patient Support Manager for further explanations of each term.

Appeal

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

Claim

A request for payment that you or your healthcare provider submits to your health insurance company when you receive items or services you think are covered.

Coinsurance

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

Copay (copayment)

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

Deductible

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

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

Extra Help

This Medicare program is designed to help people with limited income and resources pay for the costs of their covered Part D prescription drugs.

Formulary

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

Health Insurance Marketplace

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

Health Maintenance Organization (HMO)

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

High-Deductible Health Plan (HDHP)

This is a health insurance plan with a large deductible.

HDHP Coverage	Minimum Deductible	Maximum Out-of-Pocket Expense
Self only	$1700	$8500
Family	$3400	$17,000

Effective as of January 2026.

In-Network

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

Glossary of Key Insurance Terms (continued)

Medicare Part A: Hospital Insurance

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

Medicare Part B: Medical Insurance

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

Medicare Part C: Medicare Advantage

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

Medicare Part D: Drug Coverage

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

Open Enrollment

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

Out-of-Network

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

Out-of-Pocket Maximum

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

Preferred Provider Organization (PPO)

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

Premium

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

Prior Authorization (PA)

The process by which you and your doctor get approval from the health insurance company, which can include prescription medicine or diagnostic tests. PAs are requested when your plan has specific requirements that they want you to meet before approving coverage for certain items.

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

Referral

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

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We're ready when you are. Get your insurance questions answered by calling a Patient Support Manager at **1-877-77-AGIOS (1-877-772-4467)**, Mon-Fri, 8 AM to 8 PM, ET.