PROVIDING PATIENTS WITH INFORMATION

TO HELP THEM EVALUATE THEIR HEALTH INSURANCE OPTIONS

When patients are evaluating their health insurance options, they may look to their doctor’s office for information about the plans that best fit their needs. Health insurance benefits depend on patients’ individual situations. This information can help facilitate the discussions you have with your patients.

What could happen if patients change their health insurance?

Patients might discontinue therapy:
- If their out-of-pocket costs increase
- If their plan requires them to try and fail another medicine first

Patients might not be able to continue to receive the care they are used to because:
- Their current health care provider(s) and/or treatment location(s) may no longer be in-network
- They may have higher out-of-pocket costs and/or need financial assistance
- Some or all of their medications may no longer be covered by their new plan
- Their new health insurance plan may consider them “treatment naive” and require a new prior authorization
INCLUDED IN THIS GROUP OF TEAR SHEETS:

1. Information on when patients may change health insurance plans
2. Considerations/questions when selecting new health insurance plans
3. A glossary of terms

To order more tear pads, contact your Genentech representative or download the printable version at Genentech-Access.com.

You can always reach out to the Genentech Patient Resource Center for more information at (877) GENENTECH/(877) 436-3683.
WHAT TO THINK ABOUT WHEN YOU ARE CONSIDERING A CHANGE OF INSURANCE

This information may help you understand your health insurance options. That way, you can choose a plan that allows you to see the doctors you want and keep getting the medicines you have been prescribed.

When can you make changes to your health insurance?

There are 2 periods throughout the year when you may make a change to your insurance:

• Open enrollment
• A special enrollment period

Open enrollment usually happens the same time each year, depending on your plan. A special enrollment period can happen at any time and is based on changes in your life. These are sometimes called qualifying life events.

Examples of qualifying life events include:

<table>
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<tr>
<th>Changes in employment</th>
<th>Personal milestones</th>
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<td>• Starting a new job</td>
<td>• Age (e.g., loss of coverage under parents’ plan at age 26 or eligible for Medicare at age 65)</td>
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<td>• Moving to a part-time schedule</td>
<td>• A move to a different state</td>
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<td>• Loss or change of job/retirement (may need coverage from COBRA)</td>
<td>• Change in marital status (e.g., marriage, divorce or separation)</td>
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<td>• Your employer no longer provides as much coverage so it does not meet your needs, or you can no longer afford the plan</td>
<td>• Birth, adoption of a child or placement of a child in foster care</td>
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If you have health insurance through your job, your employer may change the plans it offers. You may want to review your options during open enrollment even if you were not planning to change your health insurance.
When thinking about your insurance options, here are some questions you may want to ask.

**Q. How much will my medicine(s) cost?**

**A.** Your medicine(s) will likely have a co-pay or co-insurance, depending on how it is covered. It may be covered under the medical benefit or pharmacy benefit. There may also be different costs for different medicines. It depends on the tier it is covered under.

**Q. What other costs will I need to pay?**

**A.** Find out your out-of-pocket costs:
- What your premium will be
- If you have a deductible and an out-of-pocket maximum
- What your co-pay or co-insurance for your doctors’ visits, hospital visits, tests and other health care costs will be

**Q. Can I get help paying for my medicine?**

**A.** If you need help paying for your medicine, financial assistance options may be available through the company that makes your medicine or through independent foundations. Some financial assistance options depend on the type of insurance plan you have.

**Example:** Co-pay card programs offered by the company that makes your medicine are available for people who have commercial health insurance. When you turn 65, you are eligible for Medicare. Medicare is a type of public health insurance. People who are covered by Medicare are no longer eligible for co-pay card programs and may need to seek help through an independent co-pay assistance foundation instead.

**Q. Can I keep my current doctors?**

**A.** Find out if your doctors are in-network. If they are not, find out if the plan covers out-of-network doctors and what the costs will be.
QUESTIONS TO ASK WHEN THINKING ABOUT YOUR HEALTH INSURANCE OPTIONS (CONT)

Q. Will I be able to stay on my current medicine(s)?
A. Find out if your medicine is on the plan’s formulary. The plan may also have some restrictions. These may include requiring approval or having you try another medicine first.

Q. Will the plan pay for my procedures and tests?
A. There may be other restrictions around procedures and tests, such as requiring insurance approval first.

Q. Can I still get my medicine from the same pharmacy?
A. Some plans require you to get your medicine from a certain pharmacy. This may be a mail-order or specialty pharmacy, depending on the plan and the drug. Find out if the plan has any pharmacy requirements.

Q. Can I be treated at the location I want?
A. Find out if your treatment site is in-network.

You can find the answers by talking to your employer’s human resources department or your union representative. You may also call the health insurance company directly.

Other helpful resources

| If you have commercial health insurance | • Insurance carrier brochures and websites  
• HealthCare.gov  
• Your union  
• Your human resources department |
| If you have public health insurance | • Medicare.gov  
• Benefits.gov  
• MedicareSolutions.com  
• Medicare & You booklet  
• Medicaid.gov |

Genentech Access Solutions  
Call (866) 4ACCESS/(866) 422-2377  
Visit Genentech-Access.com
GLOSSARY OF TERMS

Here is a list of terms that you have come across in bold on pages 1 through 3.

**COBRA:** This is short for Consolidated Omnibus Budget Reconciliation Act. Under this law, you may temporarily keep your health insurance coverage after your employment ends. You must pay 100% of the premium, including the share your employer used to pay, plus an administrative fee.

**Co-insurance:** An amount you have to pay for health care services or medicines. You pay this amount after you pay your deductible. Co-insurance is usually a percentage.

**Commercial health insurance:** This may also be called private health insurance. This type of insurance can be from your job, a plan you bought yourself or from a Health Insurance Marketplace (such as HealthCare.gov). Medicare and Medicaid are not considered commercial health insurance.

**Co-pay:** An amount you have to pay for health care services or medicines. You pay this amount after you pay your deductible. A co-pay is usually a set amount.

**Deductible:** The amount you must pay for health care services or medicines out of your pocket before your health insurance plan begins to pay.

**Formulary:** A list of medicines a health insurance plan covers.

A full glossary of terms is available at [HealthCare.gov/Glossary](http://HealthCare.gov/Glossary).
**Medical benefit:** The part of your health insurance plan that covers visits to your doctor’s office, hospital visits, x-rays, tests and other services. Medicines given to you by your doctor at your doctor’s office or in a hospital are often covered under the medical benefit.

**Network:** The doctors, suppliers, pharmacies, and sites of care your health insurance plan has contracted with to provide health care services. Plans offer different cost options for doctors, suppliers, pharmacies and sites of care if they are in-network or out-of-network.

**Open enrollment:** This is a set time of year when you can enroll in or change your health insurance plan. It can happen at any time of the year, depending on your plan, but it usually occurs in the fall.²

**Out-of-pocket costs:** The amount not paid by the plan that you must pay for your treatment. This includes premiums, deductibles, co-pays and co-insurance.

**Out-of-pocket maximum:** The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, co-pays and co-insurance, your health plan pays 100% of the costs of covered benefits.

**Pharmacy benefit:** The part of your health insurance plan that covers most of your prescription medicines. Medicines you take yourself (such as pills or self-injections) are most often covered under the pharmacy benefit.

**Premium:** The amount you pay your health insurance plan for coverage. How often you pay this amount can vary. For example, you might pay every month.
**Public health insurance**: This is a health insurance plan you get from the federal or state government. This includes Medicare, Medicaid, TRICARE and DoD/VA insurance.

**Qualifying life event**: A change in your situation (like getting married, having a baby or losing health coverage) that can make you eligible for a special enrollment period.

**Special enrollment period**: Health insurance plans allow changes of insurance outside of open enrollment in the event of certain life changes. These are sometimes called qualifying life events or personal milestones. If you experience one of these qualifying life events, you are allowed a special enrollment period.³

**Tier**: Drug formularies are divided into different cost levels called tiers. The tier that your medication is in determines your portion of the drug cost.

To help them evaluate their health insurance options

Health Insurance Options

With Information

Providing

Patients

This tear pad includes 3 sheets of information.

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Tear off 3 sheets of this tear pad.

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   • If their out-of-pocket costs increase
   • If their plan requires them to try and fail another medicine first

2. Patients might not be able to continue to receive the care they are used to because:
   • Their current health care provider(s) and/or treatment location(s) may no longer be in-network
   • Higher out-of-pocket costs increase

When patients are evaluating their health insurance options, they may look to their doctor’s office for information about the plans that best fit their needs. Health insurance benefits depend on patients’ individual situations. This information can help facilitate the discussions you have with your patients.