NEXT

PFIZER DERMATOLOGY
patient access

# *Understanding insurance plans and terms.*

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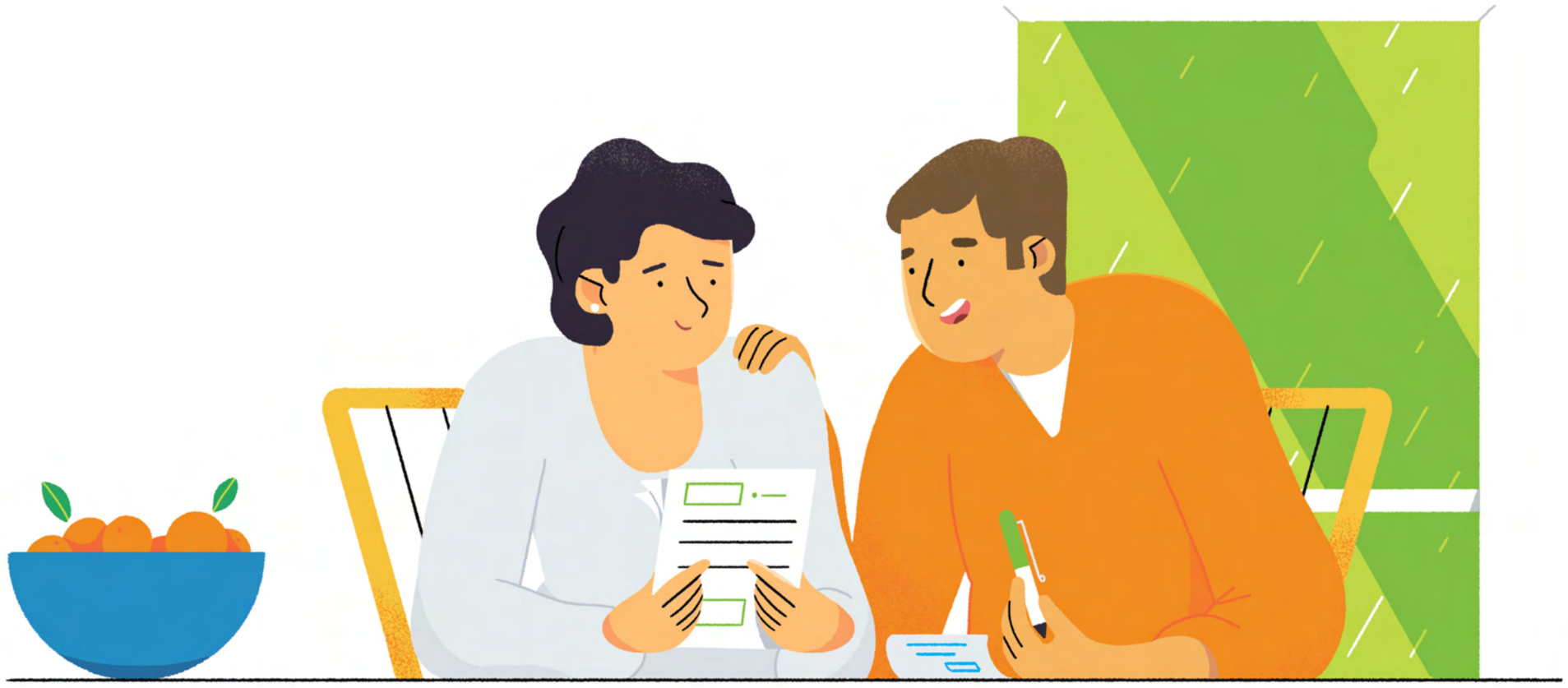
# *What is health insurance?*

Health insurance is a way to help you manage health care costs. It covers certain medical expenses for illness, injuries, or other conditions. Depending on your plan, you will pay your health insurer a monthly rate and they will pay for some or all of your medical costs. Whether you have coverage or not, there may be a few things to keep in mind before you choose a plan, including your:

- Treatment needs
- Age
- Job status
- Other conditions you may have

Be sure to talk with your benefits provider about any questions or concerns you may have about your options.

This guide includes some common insurance terms that you may hear throughout treatment. These terms are meant to be educational and may be different from the terms your plan uses, depending on your coverage. Some terms include hyperlinks to other terms in this guide. These are italicized and dark green. Keep in mind that this is not a full list.



# Government Insurance Plans

Government insurance is funded by the U.S. federal, state, or local governments. If you have a public health insurance plan, some or all of your healthcare costs may be paid for by the government.

## DUAL-ELIGIBLE

A term used to describe people who are eligible to receive both Medicaid and Medicare benefits. You can be considered "full dual-eligible" or "partial dual-eligible" depending on the amount of Medicaid benefits you receive

## LOW-INCOME SUBSIDY (LIS)

Available to people with Medicare Part D who meet limited income and resource requirements and need help paying for their Medicare prescription plan costs. This is also called "Extra Help"

## MEDICAID

A state-run program that provides free or low-cost healthcare coverage to eligible people. Medicaid typically covers people who are:

- At or below a certain income level, for example, the federal poverty level (FPL)
- People of any age with certain disabilities receiving Supplemental Security Income (SSI)
- Pregnant
- Under 18 years old

## MEDICARE

A health insurance program for people 65 and older, some people under the age of 65 with certain disabilities, and people of any age with end-stage kidney disease or amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease). There are different parts of Medicare, including:

- **Medicare Part A (Hospital Insurance)**—covers inpatient hospital stays, services, and treatments, as well as care in a skilled nursing facility, hospice care, and some home health care
- **Medicare Part B (Medical Insurance)**—covers certain doctors' services, labs, doctor-administered prescriptions, outpatient care, medical supplies, and preventative services
- **Medicare Advantage (Medicare Part C)**—an "all-in-one" alternative to Medicare that covers a bundle of Medicare plans that include Part A, Part B, and usually Part D services. This plan may also include Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs), which provide Medicare coverage in addition to other coverage to fill certain gaps. This is offered by private insurers and may provide extra benefits such as vision, hearing, dental, and more
- **Medicare Part D (Prescription Drug Coverage**)—an optional program that covers the cost of a wide range of prescription drugs and most self-administered prescription drugs, including many recommended shots or vaccines
- **Medicare Supplemental Plan (Medigap)**—fills in some of the "gaps" that Medicare Part A and Part B may not cover. This plan can help pay for some of the remaining costs, including deductibles, co-pays, and coinsurance

# *Commercial Insurance Plans*

Commercial insurance includes health plans that people buy for themselves or that employers buy for them.

## AFFORDABLE CARE ACT (ACA)

A law passed in 2010 has 3 primary goals:

- Make affordable health insurance available to more people
- Expand the Medicaid program to cover all adults with income below 138% of the federal poverty level
- Change the way certain medical decisions are made to try to lower the costs of care generally

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

This law allows you to keep your employer-sponsored health insurance temporarily under certain circumstances. It is available if:

- Your employment ends voluntarily or involuntarily *or*
- The number of hours you worked has been reduced *or*
- There is another qualifying life event, including switching jobs, death, divorce, and more

## EMPLOYER-SPONSORED HEALTH INSURANCE

Insurance that is purchased by employers for their employees and financed through the employer, or joint employer-employee contributions

## HEALTH INSURANCE MARKETPLACE

A service, created by the Affordable Care Act, where you can shop for and enroll in medical insurance online, by phone, or with help from a trained agent. There may be discounts on premiums based on your income, household size, and types of plans and benefit offerings. This is sometimes called “the Marketplace” or “the healthcare exchange”

# *Additional Accounts, Plans, and Authorizations*

### FLEXIBLE SPENDING ACCOUNT (FSA)
This is usually set up through an employee-based plan and lets you pay for many out-of-pocket medical expenses with tax-free dollars. You can decide how much to put in an FSA, based on a limit set by your employer. Keep in mind, you generally have to use the money in an FSA within the plan year, but you should talk to your employer to find out if other options are available

### HEALTH MAINTENANCE ORGANIZATION (HMO)
A type of health plan that generally will not cover out-of-network care from healthcare providers and hospitals, except in an urgent or emergency situation. With this plan, your care and referrals are usually managed by a "***gatekeeper***"

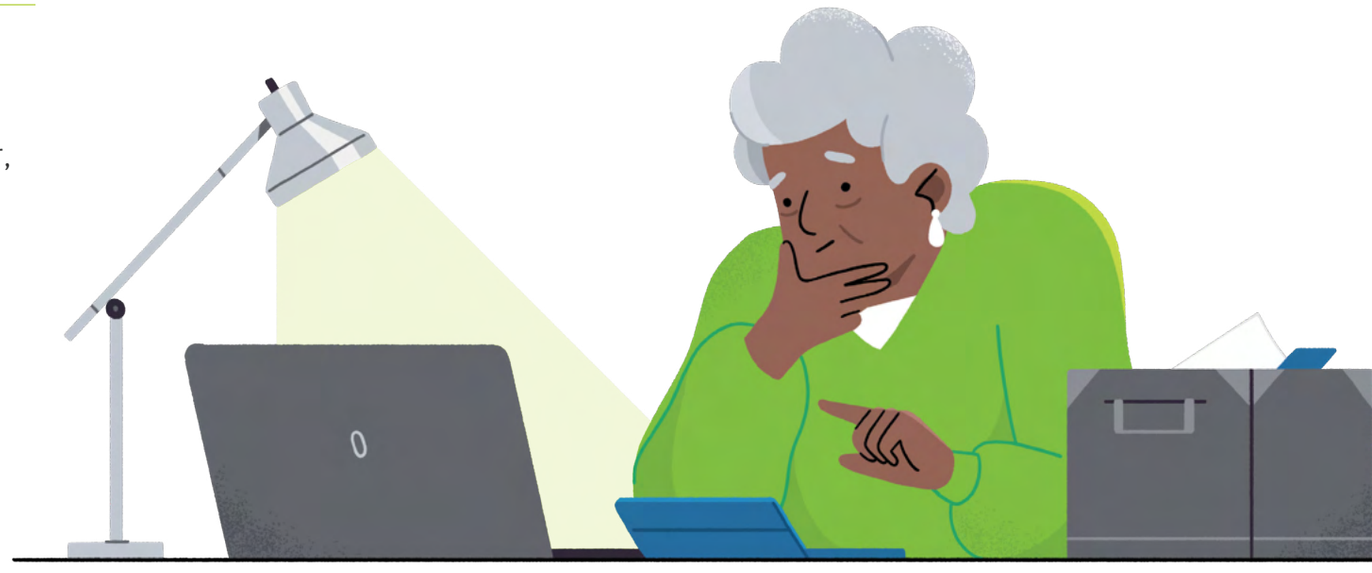
### HEALTH SAVINGS ACCOUNT (HSA)
A type of savings account that lets an employee set aside money to pay for certain healthcare expenses. In order to be eligible for this, you must be enrolled in a high-deductible health plan (HDPH)

### HIGH-DEDUCTIBLE HEALTH PLAN
A health insurance plan with a higher deductible than a traditional insurance plan. With this plan, your monthly premium is usually lower, but you are required to pay more ***out-of-pocket costs*** before the insurance company starts to pay its share

### HIPAA AUTHORIZATION
A document that authorizes the releases of medical records that are protected under the Health Insurance Portability and Accountability Act (HIPAA). This allows designated individuals to receive information about your medical condition

### MANAGED CARE PLAN
A type of health insurance plan that works with healthcare providers and hospitals to provide care at reduced costs. Some examples of managed care organizations (MCOs) are HMOs and PPOs. There are also managed care plans available if you have commercial or government insurance, including Medicaid HMOs, Medicare Managed Care (also known as ***Medicare C*** or Advantage), and commercial managed care

### PREFERRED PROVIDER ORGANIZATION (PPO)
A type of health plan where you can pay less when choosing "***in-network***" care. You can use doctors, hospitals, and other services "***out-of-network***" for an additional cost



# *Eligibility and Enrollment Terms*

**OPEN ENROLLMENT**
The annual period when you can enroll in a health insurance plan

**PRE-CERTIFICATION**
A requirement that your health insurance company must review the medical necessity of a proposed service and provide a certification number before a claim will be paid

**PRIOR AUTHORIZATION**
A step in the insurance process requiring your health provider to get approval from your insurance plan before it will cover the costs of services, appointments, or treatments. This is sometimes called preauthorization

**QUALIFYING LIFE EVENT (QLE)**
A change in your situation that can make you eligible to enroll in health insurance outside the annual open enrollment period. Some of these events may include losing existing health coverage, getting married, having a baby, or adopting a child

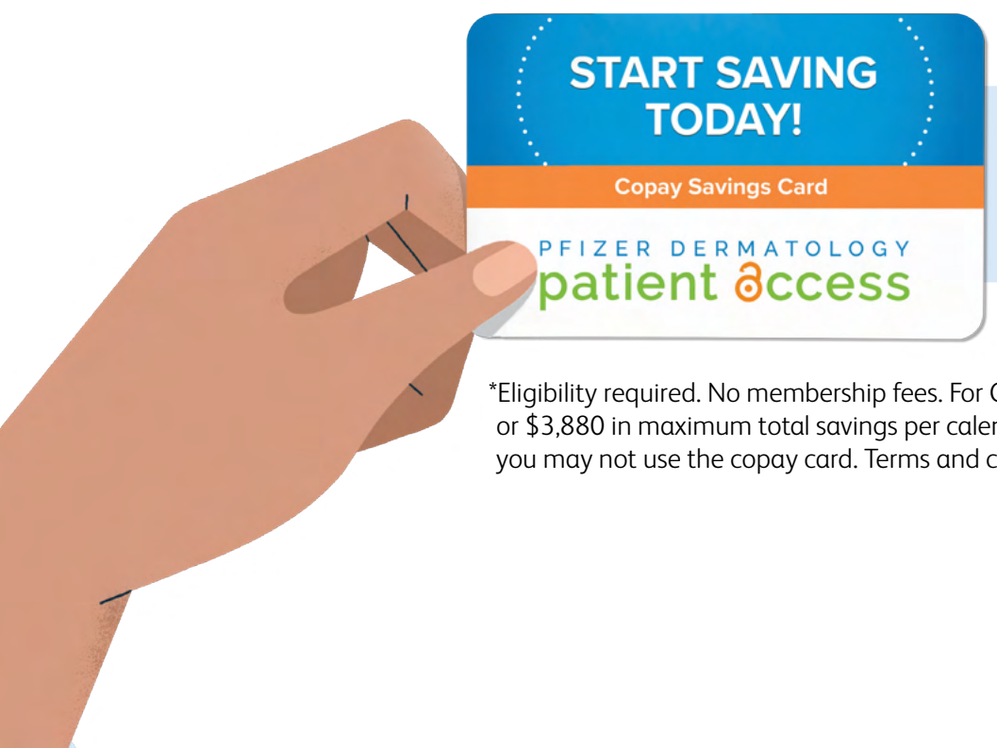
# *Cost and Coverage Terms*

### APPOINTMENT OF REPRESENTATIVE FORM
This form needs to be completed if you want to have a caregiver, loved one, or other designated individual act as your representative for coverage questions or appeals. Once the form is complete, they can request information, follow up on questions, or appeal plan decisions for you

### CLAIM
A request for payment or reimbursement that you or your healthcare provider submits to your insurance company after you receive medical services or treatments

### COINSURANCE
After you pay your ***deductible***, there's a certain percentage you have to pay for within benefit period. For example, your plan might cover 70% of your medical bill, so you will have to pay the other 30%. The 30% you pay is the coinsurance.

### CO-PAYMENT (CO-PAY)
The amount you pay to a healthcare provider or pharmacist for your visit, prescriptions, or other services. This amount may vary for different services within the same plan, including prescriptions, lab tests, or visits to specialists




If you have commercially available insurance, you may be eligible for the **Pfizer Dermatology Copay Card***

*Eligibility required. No membership fees. For CIBINQO, the maximum benefit per patient is $15,000 per calendar year. For EUCRISA, individual savings limited to $970 per tube or $3,880 in maximum total savings per calendar year. Only for use with commercial insurance. If you are enrolled in a state or federally funded prescription insurance program, you may not use the copay card. Terms and conditions apply. Link to full Terms and Conditions at https://www.cibinqo.com/savings-and-support-sign-up#terms-and-conditions.

# *Cost and Coverage Terms (cont.)*

### DEDUCTIBLE
The amount you pay for covered healthcare services or prescription medicines before your insurer pays. After you have paid your deductible, you will usually only pay a ***co-pay*** or ***coinsurance*** for covered services or prescription medicines and your insurance company pays the rest

### "DONUT HOLE"
A coverage gap that happens with most ***Medicare Part D*** plans. This means that after your plan has spent a certain amount of money for covered medicines, you have to pay out-of-pocket for all of your prescriptions (up to a yearly limit). Once you have reached the yearly limit, your coverage gap ends and your plan will help pay for covered medicines again

### EXPLANATION OF BENEFITS (EOB)
A statement from your insurer explaining what costs will be covered for medical services or treatment you've received. This is provided to you and your healthcare provider when a claim is submitted

### FORMULARY
A list of prescription medicines covered by a prescription drug plan or another insurance plan offering benefits. Sometimes, this is also called a "drug list"

### GATEKEEPER
The person in charge of your treatment through an ***HMO***. If you have this type of healthcare plan, you will be assigned a gatekeeper or you can choose one. Your gatekeeper is usually a designated primary care provider

### IN-NETWORK
Refers to healthcare providers who have a contract with your health insurance company to provide you with care and services at a discounted rate. In-network costs are typically less expensive than out-of-network costs

# *Cost and Coverage Terms (cont.)*

### OUT-OF-NETWORK
Refers to healthcare providers who do not have a contract with your health insurance company to provide you with care or services at a discounted rate. Out-of-network costs are typically more expensive than in-network costs

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### OUT-OF-POCKET COSTS
Expenses that you must pay. These costs can vary by plan and may include ***deductibles***, ***coinsurance***, and ***co-payments*** for covered services, plus all costs for services that are not covered

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### 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-payments, and coinsurance, your health plan will pay the rest

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### PREMIUM
The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your covered benefits, including a deductible, co-payments, and coinsurance

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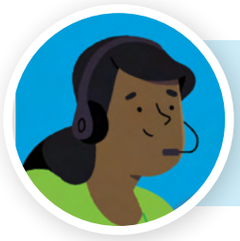
### SPECIALTY PHARMACY
This is different from a retail pharmacy and delivers medicines that require special handling, storage, and distribution requirements. They can provide services that include training on how to use the medicines, insurance support, and often work with your healthcare provider.



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