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Understanding Health Insurance Coverage— A Patient's Guide for 2027

This guide will act as an overview of health insurance available to you. It will provide you with information on Medicare, Medicaid, and commercial health insurance coverage.

It may also be used to learn key terms associated with your health insurance and help address some questions you may consider when comparing your health insurance options.

The information presented in this guide is for educational purposes only. Information is subject to change. Insurance coverage may vary by health plan, patient, and setting of care.

Table of contents

Types of health insurance 3

Medicare coverage:

- Overview of coverage 4
- Cost 5
- Prescription drug (Part D) coverage and cost sharing 6
- Frequently asked questions about prescription drug affordability 7-8
- Medicare enrollment 9
- Signing up 10
- Medigap 11
- Low-Income Subsidy (LIS) with Extra Help 12
- Understanding your Explanation of Benefits (EOB) and Medicare Summary Notice (MSN) 13

Medicaid coverage:

- Overview of coverage 14-15
- Qualifying and signing up 16

Commercial health insurance 17-18

Cost examples 19-20

The Affordable Care Act (ACA):

- The Affordable Care Act vs Medicaid 21
- Frequently asked questions about the ACA 22

Eisai Patient Support (EPS) 23

Glossary 24-25

Bolded words throughout this guide are defined in the glossary on pages 24 and 25 or are emphasized for clarity.

Eisai Patient Support is here to answer questions about your existing coverage as it pertains to your prescribed Eisai product. Visit **www.eisaipatientsupport.com** for more information.

Visit **www.medicare.gov** or **www.healthcare.gov** for more information about health insurance coverage.

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Types of health insurance

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There are many different types of insurance that may help cover some or most of the cost of the treatments or medicines prescribed to you. Each insurance type may provide different levels of coverage and may work in different ways.

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

Commercial health insurance is usually provided by employers. Coverage is based on the benefits package provided by your employer, or by your individual/family health plan.

Government-sponsored insurance includes coverage offered through programs funded by the state or federal government, such as **Medicare** and **Medicaid**.

How is commercial insurance different from government-sponsored insurance?

	MEDICARE	MEDICAID	COMMERCIAL INSURANCE
Who funds it?	Federal government	Federal and state government	Privately funded; for example, group health plans through employers, or individual plans purchased directly by consumers
How does coverage work?	Medicare provides coverage through 4 parts: • Part A: Hospital insurance • Part B: Medical insurance • Part C: Medicare Advantage • Part D: Prescription drug coverage	Under federal law, states are required to provide certain benefits and have the choice to cover additional benefits. 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.	Coverage and benefit design vary by plan, and are either privately funded through employers or purchased by individuals.
Who is eligible?	All people aged 65 years or older, as well as certain younger people with qualifying disabilities, end-stage renal disease, and people with amyotrophic lateral sclerosis	Available to eligible low-income families/individuals, qualified pregnant women and children, and people with disabilities	Employees may purchase plans through their employer, while individuals or families may purchase private plans through an insurance company.

See pages 4-13 for Medicare and pages 14-18 for Medicaid/commercial health insurance.

Learn how you can make changes to your coverage during the Medicare Open Enrollment Period on page 9.

Medicare coverage:

Overview of coverage

Medicare is the federal health insurance program for people aged 65 years or older. Medicare may be able to cover the costs of your doctors, hospital visits, and prescriptions.

When considering Medicare coverage, it is important to note that there are 4 parts of Medicare (Parts A, B, C, and D). See the table below for more detailed information.

MEDICARE PART	DETAILS
A **Hospital Insurance**	• Covers hospital visits, nursing home care, hospice • Qualified individuals may be automatically enrolled • **Free** or **no premium** for most people if you've paid payroll taxes for at least 10 years
B **Medical Insurance**	• Covers outpatient care, such as doctor's visits and visits to outpatient treatment centers for infusions or injections, some home healthcare services, medical equipment, wellness services, lab tests, and select preventative services • Requires you to pay **premiums**, **copays**, **deductibles**, and **coinsurances**, like private insurance companies would

For **Original Medicare** (Parts A and B), **Medicare Supplemental Insurance (Medigap)** is available to help pay for your **out-of-pocket** costs. Learn more on page 11.

MEDICARE PART	DETAILS
C **Medicare Advantage**	• Medicare Advantage (Part C) plans are sold by private insurance companies that are approved by Medicare. These plans include all services covered under Parts A and B with the option of Part D prescription drug coverage • Can offer additional benefits such as dental, vision, and hearing • Generally, you must have Original Medicare (Parts A and B) to enroll in a Medigap policy. Part C does not qualify for Medigap coverage • In many cases, you can only use doctors and other providers who are in the plan's network and service area (for non-emergency care). Some plans offer non-emergency coverage out of network, but typically at a higher cost
D **Prescription Drug Coverage**	• Optional prescription drug plan offered through private companies that are approved by Medicare • Covers medicines prescribed by your doctor. These are drugs you take yourself; for example, pills you swallow, injections you give yourself, and inhaled treatments

Visit **www.medicare.gov** to get the most up-to-date information. See page 6 for more information on patient **out-of-pocket** costs.

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Medicare coverage:

Cost

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What you pay for Medicare (out-of-pocket costs) will be based on what coverage and services you get, and which **providers** you visit. With Original Medicare (Parts A and B), there is no yearly limit on what you pay out-of-pocket, unless you have Medicare Supplemental Insurance (Medigap) or you join Medicare Advantage (Part C). It's important to note that for covered Part D drugs, **Medicare Part D** has an out-of-pocket cap of $2,400 in 2027.

Speak to your healthcare team about costs regarding your Medicare drug plan. This will help you to choose the best Medicare options for your needs.

MEDICARE PART COSTS	PREMIUM	DEDUCTIBLE
A **Hospital Insurance**	• **$0** for most people because you or a spouse paid Medicare taxes for at least 10 years • If you don't qualify for premium-free Part A, you might be able to buy it. For more information on Part A premiums, visit https://www.medicare.gov/basics/costs	• For information on the deductible for each **inpatient** hospital benefit period before Original Medicare (Parts A and B) starts to pay, visit www.medicare.gov/coverage/inpatient-hospital-care
B **Medical Insurance**	• Dependent on income per month, even if you don't get any Part B-covered services. Learn more at www.medicare.gov/basics/costs • This amount can change each year	• Visit www.medicare.gov/basics/costs to learn about deductible costs for Original Medicare
C **Medicare Advantage**	• **Varies by plan**. These amounts can change each year	• **Varies by plan and pharmacy**. Visit www.medicare.gov/plan-compare to compare costs and coverage of drug plans in your area
D **Prescription Drug Coverage**	• **Varies by plan**. You may have to pay more, depending on your income	• **Varies by plan and pharmacy**. Visit www.medicare.gov/plan-compare to compare costs and coverage of drug plans in your area

For more information about Medicare costs, including coinsurance and deductibles, visit **www.medicare.gov** or **www.medicareadvocacy.org**.

Beginning in 2025, changes were implemented to Medicare Part D in an effort to lower prescription drug costs for people with Medicare, including through new protections available in the Medicare Part D drug benefit, such as an annual out-of-pocket (OOP) limit for Part D drug costs and the Medicare Prescription Payment Plan.

What do you need to know about your Part D drug costs?

- In 2027, people with Medicare Part D will pay a **maximum of $2,400 per year in OOP costs** for covered Part D drugs (and for subsequent years, this amount will be adjusted based on growth in Part D per-person spending)
- In 2027, the Centers for Medicare & Medicaid Services (CMS) increased the standard deductible for Part D enrollees to $700
- OOP costs are capped at $35 per month for people taking insulin products covered with Medicare prescription drug or **Original Medicare** coverage
- Part D-covered adult vaccines are available with no deductible and no cost-sharing for people with Medicare prescription drug coverage
- Part D enrollees will be able to opt into the **Medicare Prescription Payment Plan (M3P)** to pay their OOP Part D costs in monthly amounts spread over the plan year
  - This is also referred to as **smoothing**, and is noted on page 25

Scan the QR code to learn more about the option of spreading your Medicare Part D out-of-pocket costs throughout the year, or visit **www.cms.gov/priorities/medicare-prescription-drug-affordability**.

What is the Medicare Prescription Payment Plan (M3P)?

M3P is a program administered by Medicare Part D insurance plans to help manage OOP prescription drug costs for Part D participants. This program helps by spreading those costs into monthly payments over the calendar year.

- M3P is a voluntary program available to individuals enrolled in a Medicare Part D or Medicare Advantage prescription drug plan
- It may help make covered prescription drug costs more manageable throughout the year
- M3P does not reduce what you pay—it simply spreads your costs over time. There are no fees or interest charges to participate
- Rather than paying at the pharmacy, your prescription drug plan will send you a separate monthly bill for the amount you owe
- You must opt in to participate and can do so anytime throughout the year, including during Medicare Open Enrollment

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What if a beneficiary chooses to opt in to M3P?

- Enrollees pay $0 for their Part D prescription drug at their pharmacy at time of purchase
- The monthly bill is based on the cost of their prescriptions plus any previous month's balance (if any), divided by the number of months left in the year
- In addition to their monthly premium, enrollees will be billed monthly by their Part D plan for drug costs owed

How do you opt into/sign up for M3P?

- Telephone: Call the phone number on your Medicare Prescription Drug Plan card
- Paper request: Fill out a paper election request from the plan
- Online: Choose this option through the plan's website, or visit **GetMyMeds.com**

Beneficiaries may not sign up for M3P at their pharmacy or point of sale.

Note: When opting into the program, it may take the Part D or Medicare Advantage plan up to 24 hours to process the election.

For more information, visit **www.medicare.gov/prescription-payment-plan**.

Speak to your Part D insurer for more information.

Continue to the next page for more answers to frequently asked questions.

Frequently asked questions about prescription drug affordability (cont'd)

When can you opt in?

For M3P, those with Medicare Part D or who enroll in Part D in 2027 can voluntarily opt into the program at the time of enrollment or later throughout the plan year. Enrollment must be through your plan, and will not be available at the point of sale, such as a pharmacy. Speak to your Part D insurer for more information.

Do these prescription drug cost protections apply to drug coverage in Medicare Advantage plans?

Yes, they also apply to people who have drug coverage through a Medicare Advantage plan. Participation in M3P requires Part D enrollees to opt into the program; speak to your Part D insurer for more information. Enrollees who participated in the prior year are automatically re-enrolled for the next calendar year unless you opt out, switch plans, or were removed for missing payments. Plans will send a renewal notice after Open Enrollment and must process opt-out requests within 3 calendar days.

Do people with Medicare need to take any action?

People with Medicare should continue to review and compare their health and drug plan options during **Open Enrollment**, which runs from **October 15 through December 7** every year. Since plan costs and coverage can change annually, it is important to review your current plan's coverage during Open Enrollment and compare to other options for the 2027 plan year. Please note, beneficiaries who previously opted in to M3P, and have the same plan, will automatically be re-enrolled for 2027.

Scan the QR code to learn more about Medicare prescription drug affordability at **www.cms.gov/priorities/medicare-prescription-drug-affordability**.

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Medicare enrollment

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Although Medicare is typically for people 65 years or older, you may be eligible to get Medicare earlier if you have a disability, end-stage renal disease (ESRD), or amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease.

Some people get Medicare automatically, while others have to actively sign up—it depends if you start getting retirement or disability benefits from Social Security before you turn 65.

What is Open Enrollment?

Open Enrollment is your chance to review your current health insurance coverage and evaluate whether it still meets your needs. You can also make changes to your health or prescription drug coverage plan for the upcoming year. During this process, you can keep your **current plan** or **compare plans** to find the right coverage for you.

Mark your calendars with these important dates! Medicare Open Enrollment is from **October 15 through December 7**.

When does Open Enrollment happen?

Open Enrollment takes place every year from October 15 through December 7. The healthcare coverage you select during this time will begin on January 1 and go all the way through December 31 of the following year. However, this will only happen if you select a healthcare coverage plan by December 7.

Please note that there are other limited circumstances where you may be eligible to change your enrollment outside of the Medicare Open Enrollment period. If you're new to Medicare, you don't have to wait for Open Enrollment to sign up—you can enroll once you become eligible.

Scan the QR code for more information about Medicare Open Enrollment, or visit **www.medicare.gov/plan-compare**.

When can you change your Medicare Advantage plan?

If you're already enrolled in a Medicare Advantage plan, you have another opportunity to make a change. From January 1 through March 31, you can switch to a different Medicare Advantage plan or return to Original Medicare. If you return to Original Medicare, you can also join a separate Medicare drug plan. Your new coverage starts the first of the month after your request is processed.

Visit **www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan** for more information on Medicare Advantage enrollment.

Signing up

There are 2 ways to sign up for Medicare

Sign up by telephone by calling **1-800-MEDICARE (1-800-633-4227)** or by calling the Social Security office at **1-800-772-1213**

Apply online by filling out an application at www.medicare.gov/basics or by visiting www.SSA.gov/medicare

Additional resource

Get free, local one-on-one insurance counseling by visiting the State Health Insurance Assistance Program (SHIP) at **www.shiphelp.org** or by calling **1-877-839-2675.**

Newly eligible for Medicare? You don't need to wait for Open Enrollment to sign up. Scan the QR code to find out more about when Medicare coverage starts, or visit **www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start**.

Medicare Open Enrollment is from **October 15 through December 7**. During this time, you can sign up, make changes, or review your current plan.

For more information about Medicare Open Enrollment, visit **www.medicare.gov/plan-compare**.

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Medigap

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Medicare Supplemental Insurance (Medigap)

If you have Medicare Parts A and B, **Medicare Supplemental Insurance (Medigap)** can help pay some of the costs that are not covered by Original Medicare. Medigap policies are sold by private insurance companies.

How do I get Medigap?

To qualify for Medigap, you must have Original Medicare (Medicare Parts A and B); you cannot get Medigap if you have Medicare Advantage (Part C).

When can I get Medigap?

You get a 6-month "Medigap Open Enrollment" period, which starts the first month you have Medicare Part B and you are 65 years or older.

During this time, you can enroll in any Medigap policy, and the insurance company can't deny you coverage due to **pre-existing conditions**. After this period, you may not be able to buy a Medigap policy, or it may cost more. Your Medigap Open Enrollment period is a one-time enrollment and is automatically renewed every year.

Learn more about Medigap at **www.medicare.gov/health-drug-plans/medigap**.

Medicare coverage:

Low-Income Subsidy (LIS) with Extra Help

Extra Help

Extra Help is a benefit from the federal government that helps pay for Medicare Part D costs. You may be able to get Extra Help if you are low-income or have limited assets, including in your checking or savings account.

Extra Help may include:

- No premium (or zero-dollar premium)
- No deductible (or zero-dollar deductible)
- Lower out-of-pocket costs for both brand-name and generic prescriptions
- The opportunity to change your Medicare plans at any time. The changes you make will become active on the first day of the next month

How 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 to apply if you:

- Already have full Medicare coverage and are also eligible for Medicaid (dual eligibility)
- Get help from Medicaid to pay for Part B
- Get Supplemental Security Income benefits

Learn more about Low Income Subsidy with Extra Help at **www.cms.gov/medicare/enrollment-renewal/part-d-plans/low-income-subsidy**.

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Medicare coverage:

Understanding your Explanation of Benefits (EOB) and Medicare Summary Notice (MSN)

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Under your coverage, after you receive treatment, your health plan will send you an EOB or MSN. The MSN is a summary of covered services under Medicare Parts A and B.

These documents are statements and are not bills. They are records of the services you received. They will tell you how much your treatment or care costs, how much your plan will pay toward those costs, and how much you may need to pay.

Your EOB or MSN will also tell you if services weren't covered by your health plan. The EOB or MSN is an important document to use if you disagree with your plan's decision on your **claim**. If your plan denies coverage, contact your doctor's office to confirm if they plan to file an **appeal** for you.

Here's an example of an EOB

1 **Phone Numbers:** You can call your health insurance plan if you have questions about finding a provider or what your coverage includes.

2 **Payee** is the person who will receive any reimbursement for overpaying the claim.

EXPLANATION OF BENEFITS
Statement Date: XXXXXX
Document Number: XXXXXXXXXX

THIS IS NOT A BILL
Subscriber Number: XXXXXXXXXX

1 Customer Service Number: 1-800-123-4567
Member Name:
Address:
City, State, Zip:

ID: XXXXXXX
Group: ABCDE
Group Number: XXXXX

Patient Name: XXXXXX
Date Received: XXXXXXXXXX
Provider:
Payee: **2**
Claim Number: XXXXXXXX
Date Paid: XXXXXXXX

3 **Service Description** shows the health services you received, like a medical visit, lab test, or screening.

4 **Provider Charges** is the amount your provider bills for your visit.

5 **Allowed Charges** is the amount your provider will be paid; this may not be the same as the Provider Charges. *This is a combination of what your plan will pay and your responsibility.*

Detail Claim				What Your Provider Can Charge You		Your Responsibility			Total Claim Cost		
		3		**4**	**5**				**6**	**7**	**8**
Line No.	Date of Service	Service Description	Claim Status	Provider Charges	Allowed Charges	Copay	Deductible	Coinsurance	Paid by Insurer	What You Owe	Remark Code
1	3/20/27-3/20/27	Medical care	Paid	$31.60	$2.15	$0.00	$0.00	$0.00	$2.15	$0.00	PDC
2	3/20/27-3/20/27	Lab test	Paid	$375.00	$118.12	$35.00	$0.00	$0.00	$83.12	$35.00	PDC
			Total	$406.60	$120.27	$35.00	$0.00	$0.00	$85.27	$35.00	PDC

Remark Code: PDC-billed amount is higher than the maximum payment insurance allows. The payment is for the allowed amount.

6 **Paid by Insurer** is the amount your health plan will pay to your provider.

7 **What You Owe** is the amount you owe after your insurer has paid everything else. You may have already paid part of this amount. Payments made directly to your provider may not be subtracted from this amount.

8 **Remark Code** is a note from the health plan that explains more about the costs, charges, and paid amounts for your visit.

Medicaid coverage:

Overview of coverage

Medicaid is a state-run health insurance program that is regulated by federal law to provide certain benefits and offers the choice to cover additional benefits.

Medicaid changes in 2027

Some adults covered through Medicaid expansion will have eligibility redeterminations every 6 months (instead of annually), which applies to renewals scheduled on or after **January 1, 2027**. Traditional Medicaid populations, including children, pregnant women, older adults, and people with disabilities will continue to renew every 12 months.

Beginning no later than **January 1, 2027**, some adults ages 19-64 covered through Medicaid expansion will need to meet a community engagement requirement to gain or maintain Medicaid eligibility. This may include completing at least 80 hours per month of work, community service, a work program, or part-time school enrollment. Some individuals, including pregnant women, medically frail individuals, and caregivers or young children, may be exempt. If you have any questions about your Medicaid coverage, or additional requirements, contact your state's Medicaid agency.

Who is covered under Medicaid?

Medicaid coverage is provided to:

- Eligible low-income adults
- Eligible low-income pregnant women
- People with disabilities who qualify
- Eligible children
- Eligible elderly people

Coverage varies by state. The following states have not yet adopted Medicaid expansion: AL, FL, GA, KS, MS, SC, TN, TX, WI, and WY.

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What does Medicaid cover?

Medicaid covers 2 kinds of benefits:

- Mandatory benefits, which are required under federal law
- Optional benefits, which are dependent on the state you live in

The list below notes some of the mandatory benefits covered by Medicaid.

MANDATORY BENEFITS

- Inpatient hospital services
- Outpatient hospital services (infusion/treatment center)
- Early and periodic screening and diagnostic and treatment services
- Nursing facility services
- Home healthcare services
- Physician services
- Rural and federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services
- Transportation to medical care
- Tobacco-cessation counseling for pregnant women

What will my cost for Medicaid be?

Your state may require you to pay certain costs for Medicaid, including copays, coinsurance, and deductibles.

For more information about Medicaid costs, visit **www.medicaid.gov** or **www.CMS.gov**.

Medicaid coverage:

Qualifying and signing up

How do I know if I qualify for Medicaid?

Since Medicaid is a state-run program, each state will have 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. Contact your state Medicaid office if you have questions about specific income eligibility requirements in your state.

For your state office information, visit **www.medicaid.gov** or call **1-877-267-2323** and follow the prompts.

To apply for Medicaid, you may

Fill out an application at your **local Medicaid office**	Call the number for your state at https://www.medicaid.gov/about-us/contact-us	Fill out an application through the **Health Insurance Marketplace®** at www.healthcare.gov

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Commercial health insurance

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When it comes to commercial insurance, your employer may be able to offer you different types of plans that meet different needs.

Some types of plans restrict your provider choices or encourage you to get care from the plan's **network** of doctors, hospitals, pharmacies, and other medical service providers. Others pay a greater share of costs for providers outside the plan's network.

Here are a few types of these plans you may encounter:

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).

Health Maintenance Organization (HMO): A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally doesn'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. HMOs often provide integrated care and focus on prevention and wellness.

Non-Network Qualified Health Plan (Non-Network QHP): A health insurance plan that is not part of your current plan's network and may have different providers, coverage rules, and costs. You may pay more for care or have different coverage depending on the plan's benefits and requirements.

Qualified Health Plan (QHP): A health insurance plan certified by the Health Insurance Marketplace that meets Affordable Care Act standards. QHPs must cover essential health benefits, such as doctor visits, hospital care, and prescription drugs, and follow set limits on what you pay out of pocket, like deductibles and copays.

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. POS plans require you to get a referral from your **primary care** doctor in order to see a specialist.

Preferred Provider Organization (PPO): A type of health plan where you pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

Commercial health insurance (cont'd)

What do commercial insurance plans cover?

Under these types of plans, you can typically expect coverage for:

- Outpatient care
- Hospital visits
- Hospitalization
- Mental health services
- Non-Network Qualified Health Plans (Non-Network QHPs)
- Prescriptions
- Laboratory and diagnostic testing
- Preventative care services
- Chronic disease management services

What is my shared cost for commercial insurance?

If you choose to get commercial health insurance through an employer, employers tend to cover at least 50% of premium costs. If you choose to purchase private health insurance on the marketplace, you may be eligible for financial assistance depending on your income level.



For more information about commercial health insurance, you may visit **www.healthcare.gov** or search online for "insurance marketplaces in my area."

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Cost examples

What will I have to pay for my treatment or medicine?

When it comes to paying for your coverage, the first thing you will pay for is your monthly premium. A **premium** is the monthly amount you pay for your health insurance coverage.



Beyond your premium, you will also have to pay toward your deductible. A **deductible** is the amount of money you must pay each year for covered services and treatments before your insurance company starts to pay for them.

You may have a separate deductible for your pharmacy benefit and medical benefit.

You may also have a **copay** or a fixed payment for covered healthcare services after you've paid for your deductible. Copays can vary for different services within the same plan; for example, drugs, lab tests, and visits to specialists.

Cost examples (cont'd)

To help you understand insurance costs, the following examples* show you 2 patients with different deductibles and how coinsurances and copays work in these instances.

Understanding coinsurance

Instead of a copay, some health insurance plans have coinsurance. This is when an insurance plan will only pay a certain percentage of the cost of treatment once your deductible is met, usually about 80%. You will be responsible for the other 20%.



Chris has a deductible of

$1,500

80%

Once Chris meets his deductible, his insurance will pay for 80% of costs

20%

Chris is now responsible for paying a 20% coinsurance

Understanding copays



Amy has a deductible of

$600

Amy utilizes healthcare services that require her to meet and pay her deductible within the first 3 months of the year

Amy now pays her $15† copay for physician office visits because her deductible has been paid in full

*These scenarios are for illustrative purposes only and are not indicative of actual insurance costs.
†Copay amount varies based on plan.



You may also visit **www.eisaipatientsupport.com** for more information on access to Eisai products.

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The Affordable Care Act (ACA):

The Affordable Care Act vs Medicaid

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Understanding the Affordable Care Act (ACA)

The ACA is a law that gives most uninsured people in the US access to health insurance through the marketplace or individual plans. It is important to note that plans under the ACA are **exchange** plans.

Beyond that, the ACA is designed to ensure that health insurance is affordable for people regardless of their incomes. People at all income levels can sign up for health insurance under the ACA.

How is the ACA different from Medicaid?

	ACA EXCHANGE PLANS	MEDICAID
Basics	• Provides basic coverage requirements for all Americans and sets standards for required coverages offered by health plans	• Joint federal- and state-funded social welfare program that provides free or low-cost coverage to low-income Americans
Enrollment	• Enrollment is only open annually from November 1 through December 15	• Annual Open Enrollment is from October 15 through December 7. You can apply for and enroll in Medicaid at any time of the year. Coverage can begin as soon as you are found eligible
Costs	• Out-of-pocket costs vary between different levels of ACA plans (Catastrophic, Bronze, Silver, Gold, and Platinum) and whether or not an individual is qualified for any additional cost-sharing assistance	• Medicaid requires little or no payments by means of copays, deductibles, etc
Eligibility	You may qualify for the ACA, if you: • Live in the US • Are a US citizen, US national, or are a lawful resident in the US • Are not incarcerated • Are not covered by Medicare Depending on your income level, you may be eligible for assistance with your premiums and cost-sharing for an ACA plan	• Medicaid eligibility is determined based on several criteria including finances, medical necessity, and the state in which you live. See https://www.medicaid.gov/medicaid/eligibility-policy for more information

Frequently asked questions about the ACA

What can I expect from coverage under the ACA?

Under the ACA, there are 10 essential benefits that are included in minimum essential coverage:

- Pediatric services
- Preventative care, wellness services, and chronic disease management
- Emergency services
- Hospital-stay coverage
- Prescription drug coverage
- Pregnancy, maternity, and newborn care
- Mental health and addiction services
- Ambulance patient services
- Laboratory services
- Rehabilitative and habilitative services and devices

What are my shared costs under the ACA?

Your premium, or the amount you might pay monthly for health coverage under the ACA, will vary depending upon where you live, your income, your household size, what plan you choose, and the amount of your premium tax credit.

To enroll for health coverage under the ACA, visit **www.healthcare.gov**.

Use the “find local help” tool to locate in-person assistance with a trained agent in your area to walk you through the **Health Insurance Marketplace** process (services are free).

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Eisai Patient Support (EPS)

Once you are prescribed an Eisai treatment, EPS can provide information regarding financial assistance programs for eligible patients, navigating insurance, or other support resources. EPS is here to support you throughout your treatment journey.

Always talk to your doctor and healthcare team if you have questions about managing your treatment costs.

Scan the QR code for more information on Eisai Patient Support programs, or visit **www.eisaipatientsupport.com**.

Eisai cannot guarantee payment of any claim. Coding, coverage, and reimbursement may vary significantly by payer, plan, patient, and setting of care. Actual coverage and reimbursement decisions are made by individual payers following the receipt of claims. For additional information, customers should consult with their payers for all relevant coding, reimbursement, and coverage requirements. It is the sole responsibility of the provider to select the proper code and ensure the accuracy of all claims used in seeking reimbursement. All services must be medically appropriate and properly supported in the patient medical record.

The information contained herein is provided for educational purposes only and is subject to change. It is not intended to replace discussions with a healthcare professional. All decisions regarding patient care must be made with a healthcare professional, considering the unique characteristics of the patient.

This guide is intended for residents of the United States only.

Glossary

As you navigate your way through enrolling or reviewing your health insurance, here are some common terms you may come across:

Appeal: A request for your health insurance company or the Health Insurance Marketplace to review a decision that denies a benefit or payment.

Beneficiary: A person who is eligible to receive benefits or coverage from a health insurance plan or government program.

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

Coinsurance: A percentage of the cost of treatment that an insurance plan will pay when your deductible is met.

Copay: A fixed amount you pay for covered healthcare services after you've paid your deductible. Copays can vary for different services within the same plan; for example, drugs, lab tests, and visits to specialists.

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

Exchange: Another term for the Health Insurance Marketplace, a service available in every state that helps individuals, families, and small businesses shop for and enroll in affordable medical insurance. The Marketplace is accessible through websites, call centers, and in-person assistance.

Health Insurance Marketplace: The Health Insurance Marketplace is a place where you can 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.

Inpatient: Healthcare that you get when you're admitted as an inpatient to a healthcare facility, like a hospital or skilled nursing facility.

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 health coverage to adults, children, pregnant women, the elderly, and people with disabilities who qualify for Medicaid benefits.

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.

Medicare Advantage Plan, also known as Medicare Part C: A type of Medicare health plan offered by a private company that contracts with Medicare.

Medicare Part D: A voluntary, government-approved prescription drug coverage plan run by private insurance companies that helps pay for both generic and brand-name outpatient prescription drugs.

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Glossary (cont'd)

Medicare Prescription Payment Plan (M3P): M3P is a voluntary program to help eligible patients manage out-of-pocket (OOP) prescription drug costs by spreading those costs into monthly payments over the calendar year. This is also referred to as "smoothing."

Medicare Supplemental Insurance (Medigap): Extra insurance you can buy from a private health insurance company to help pay your share of out-of-pocket costs in Original Medicare (Parts A and B).

Network: The facilities, providers, and suppliers your health insurer or plan has contracted with to provide healthcare services.

Non-Network Qualified Health Plan (Non-Network QHP): A health insurance plan that is not part of your current plan's network and may have different providers, coverage rules, and costs. You may pay more for care or have different coverage depending on the plan's benefits and requirements.

Original Medicare: The traditional Medicare program administered directly by the federal government that includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance). Beneficiaries can generally receive care from any provider that accepts Medicare. Original Medicare is also commonly referred to as Medicare Fee-for-Service (FFS).

Out-of-pocket: The money you pay for your healthcare costs out of your own pocket. This amount is not paid back by your insurance company.

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

Pre-existing condition: A health problem, like asthma, diabetes, or cancer, you had before the date that new health coverage starts. Insurance companies can't refuse to cover treatment for your pre-existing condition or charge you more.

Primary care: Healthcare services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with you and advise and treat you on a range of health-related issues. They may also coordinate your care with specialists.

Provider: A physician, nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of healthcare services.

Qualified Health Plan (QHP): A health insurance plan certified by the Health Insurance Marketplace that meets Affordable Care Act standards. QHPs must cover essential health benefits, such as doctor visits, hospital care, and prescription drugs, and follow set limits on what you pay out of pocket, like deductibles and copays.

Information in this brochure is sourced from medicare.gov, medicaid.gov, census.gov, healthcare.gov, CMS.gov, HHS.gov, healthinsurance.org, BLS.gov, and SSA.gov.

Questions about how to access your current Eisai treatment?
Visit **www.eisaipatientsupport.com**.

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Eisai Patient Support