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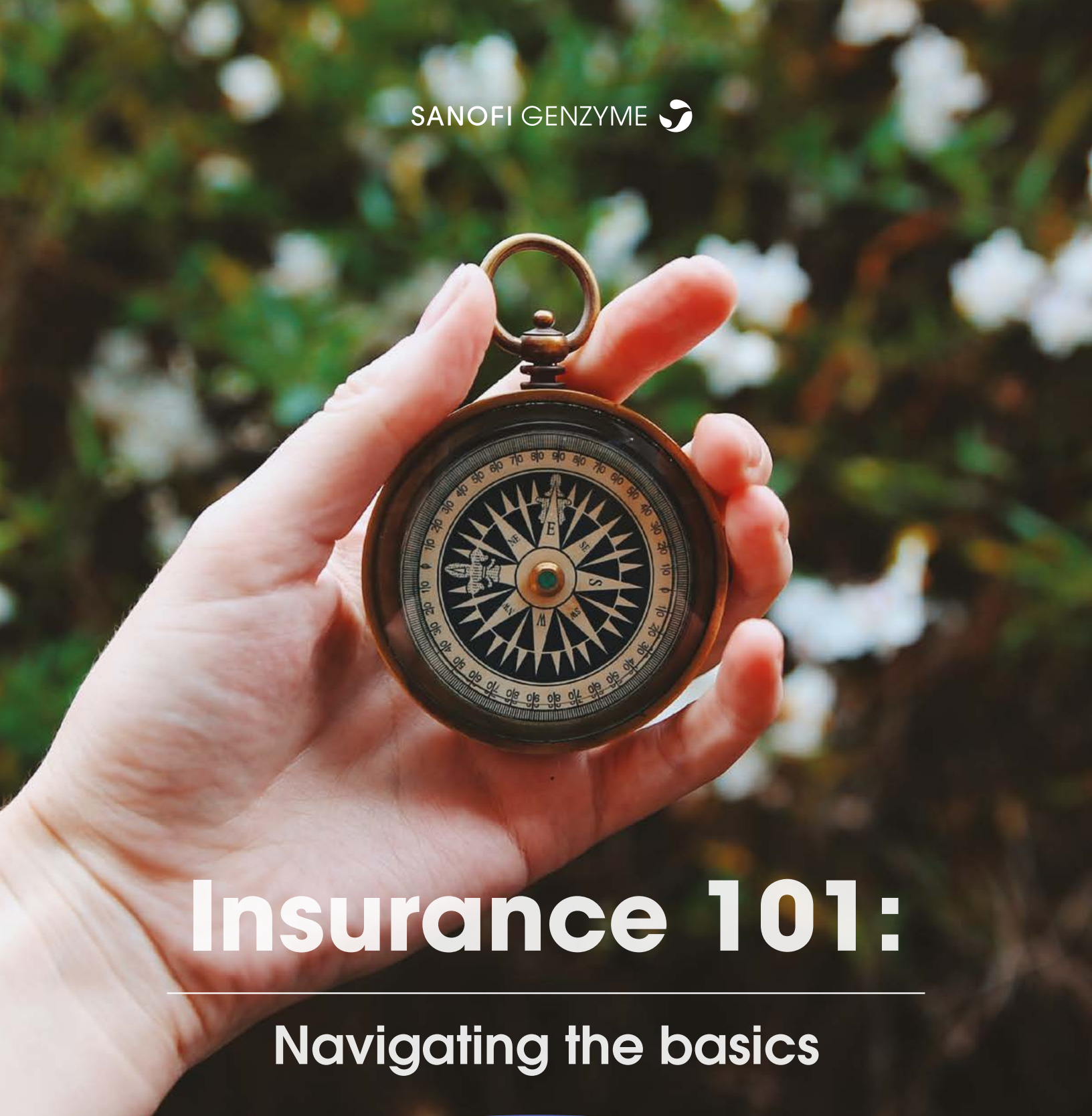
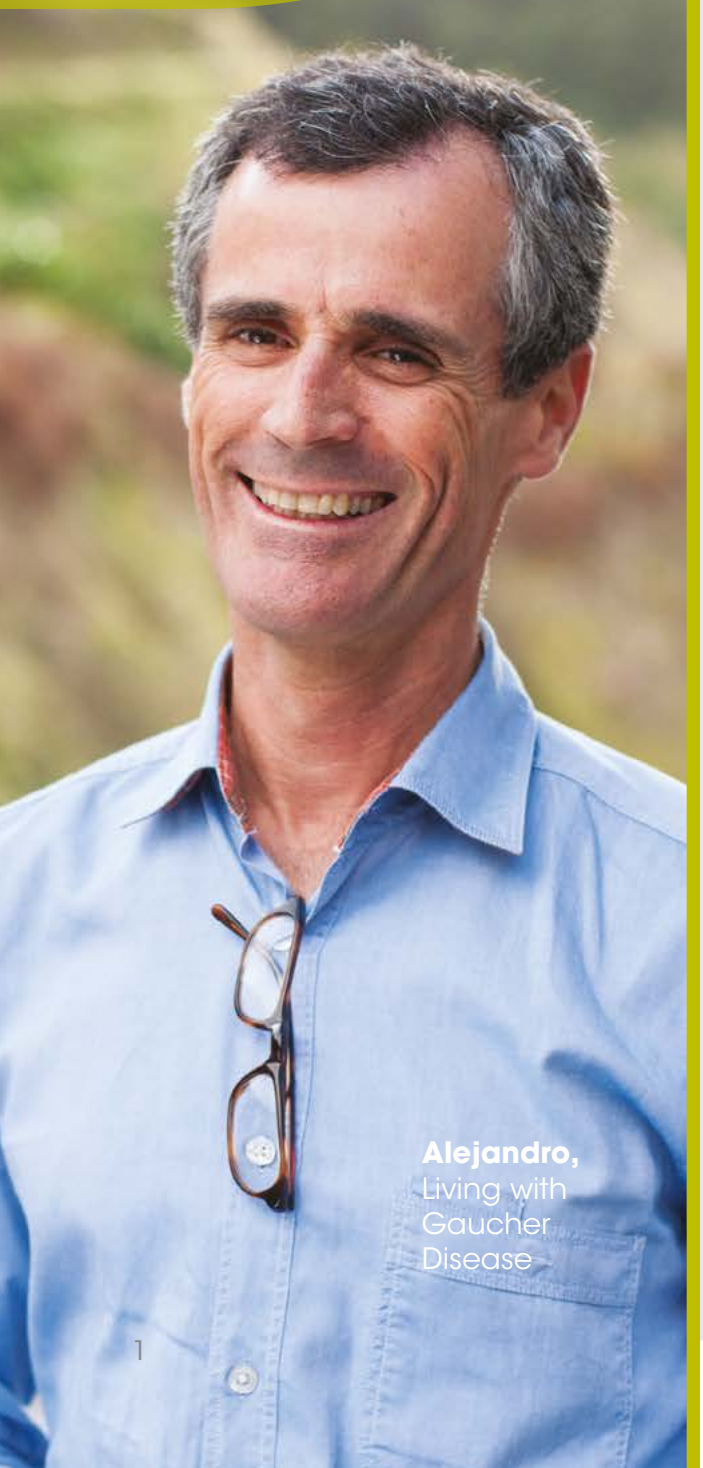


Insurance 101:

Navigating the basics

careconnect PSS®
Personalized Support Services

MAIN TYPES OF HEALTH INSURANCE COVERAGE



Alejandro, Living with Gaucher Disease

Group coverage

- Private plan provided through **your small or large employer** to cover groups of people.
- Coverage is based on the benefits package selected by your employer.
- Employers may offer different plan options to their employees.
- Small employers may have the option of obtaining group coverage for their employees through the **Health Insurance Exchange Marketplace** in their state.
- **COBRA Insurance:** COBRA stands for Consolidated Omnibus Budget Reconciliation Act. It is available to an individual and their dependents after becoming unemployed or after a reduction of working hours and is typically more expensive than the insurance cost when employed because the individual pays for the full cost (vs employer participating). Typically lasts up to 18 months after becoming unemployed and under certain conditions extends up to 36 months.

Individual/non-group coverage

- Private plan purchased by an individual for him/herself and family.
- Can be purchased through the **Health Insurance Marketplace** (Healthcare Insurance Exchange), which provides various benefit options to fit your budget and access to premium subsidies for qualified individuals.
- Insurers may also sell policies directly to individuals outside of the marketplace.
- **Catastrophic Health Insurance.** To qualify for a Catastrophic plan, you must be under 30 years old OR get a "hardship exemption" because the Marketplace determined that you're unable to afford health coverage.

Government-sponsored insurance

- Coverage funded with federal and/or state dollars.
- **Medicare:** health insurance program funded by the federal government for people over age 65 and to some people younger than 65 with disabilities or end stage renal disease.
- **Medicaid:** health insurance funded by both federal and state government for low-income people and people with disabilities.

Types of health insurance plans

Different types of plans have different rules. These rules may impact which doctors you can see, prior authorization requirements, and out-of-pocket costs.

HMO (Health Maintenance Organization)

- Limits coverage to a local network of doctors
- Requires a referral from your primary care provider (PCP) to see a specialist
- Lower monthly premiums

PPO (Preferred Provider Organization)

- Offers more flexibility and choice in your healthcare
- Offers coverage for providers who may be in or out of network. Cost sharing may be higher for out-of-network care
- Does not require a referral to see a specialist

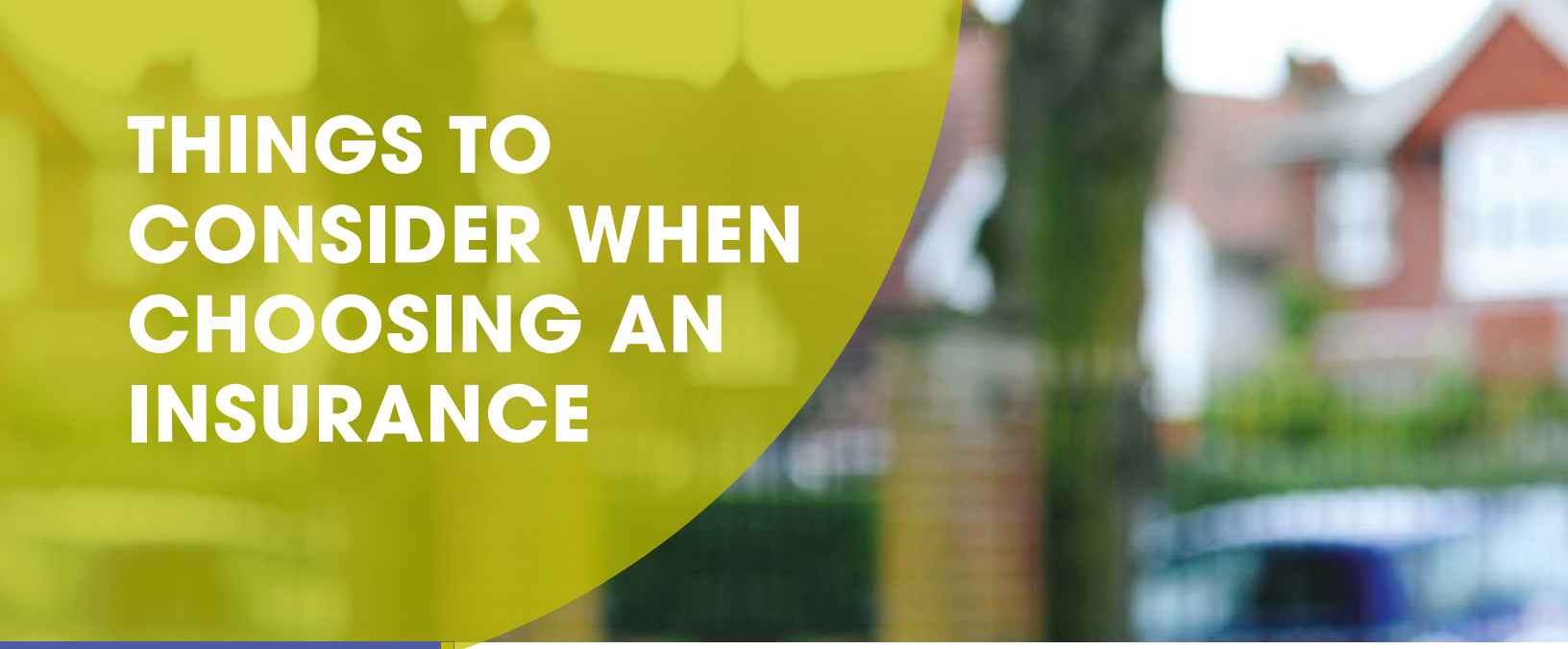
EPO (Exclusive Provider Organization)

- Limits coverage to a local network of doctors
- Does not include coverage for out-of-network care
- May not need a referral to see a specialist

POS (Point of Service)

- Similar to EPO or HMO coverage but may offer limited out-of-network flexibility

THINGS TO CONSIDER WHEN CHOOSING AN INSURANCE



Questions you may have:

Can I afford to pay my premiums and out-of-pocket costs?

What does the plan cover and can I get the services I need?

Will I have to change doctors?

How much flexibility do I want in choosing a doctor?

Are my prescriptions covered?

Costs

Premium: the amount charged per month to keep your plan active; this cost may be shared between the employer and employee for employer-provided plans

Out-of-pocket costs are in addition to the premium.

- **Co-payment:** set amount you pay for a medical service
- **Deductibles:** the amount you must pay before your insurance covers most covered services
- **Co-insurance:** a percentage-based cost share you are responsible for paying for a medical service

Some plans have lower monthly premiums but higher deductibles. Other have higher monthly premiums with lower deductibles.

Out-of-pocket maximum: the most you would have to pay in a plan year; your deductible, coinsurance, and copay contributions typically accrue towards satisfying this requirement. Premium payments do not count towards this limit.

Sam,
Living with
Pompe
Disease

Provider Network

The facilities, providers, and suppliers your plan works with to provide healthcare services.

Some networks may be larger than others and may include different choices of providers. Make sure your provider is part of the network associated with that plan, or you may have to change doctors.

- **In-network:** doctors, hospitals, or other providers that participate in your insurance plan.
- **Out-of-network:** doctors, hospitals, and other providers who DO NOT participate with your health plan. Some plans may provide some coverage for out of network care but your out of pocket costs may be higher.

Benefits Coverage

There are certain essential benefits that all plans will cover, such as doctor visits, hospital visits, preventive and diagnostic care.

Plans will have a covered drug list called a formulary or preferred drug list. Covered drugs will vary by plan. Your copays may vary based on how your plan covers brand name and generic medications.

Make sure the plan benefits and prescription drug coverage meet your needs.

LIFE CHANGES THAT AFFECT YOUR HEALTH INSURANCE

Julia,
Living
with Fabry
Disease

Sometimes you may need
to change your health insurance
outside of the yearly open enrollment period.

Qualifying Life Event: a major life change that may affect your access to health insurance or may require you to change your current insurance plan.

- Changes in **employment status** (starting, changing, or leaving a job)
- Changes in **family status** (marriage, having a child, divorce)
- **Moving** to a different state or country
- **Age** milestones
  - Turning 18 and losing coverage under state Medicaid or children's health insurance programs
  - Turning 26 and losing coverage under a parent's insurance plan
  - Turning 65 and qualifying for Medicare

qualifying life event → **special enrollment (60 days)** → health insurance changes

Qualifying life events may trigger a **special enrollment period** to make changes to your health insurance. Typically, this gives you **60 days** from the date of the life event to change health insurance plans.

Depending on your life event, you may be eligible to extend your existing employer-sponsored coverage under COBRA guidelines (Consolidated Omnibus Budget Reconciliation Act). Refer to the Department of Labor website for details (www.dol.gov).

Glossary of key terms

- **Claim:** Form submitted to an insurer to obtain reimbursement for medical services
- **Co-Insurance:** Percentage or amount of the healthcare costs that you are responsible for. Most insurance plans have a ratio of 90/10 or 80/20, 70/30, etc. For example, the insurance carrier pays 80% and you would pay 20% of the costs.
- **Co-Pay:** Set amount that you pay at each doctor visit/for each service as defined by the insurance plan.
- **Commercial insurance:** Health insurance coverage offered to groups or individuals through private insurers. These policies may be purchased through an employer, a broker, or a public health insurance marketplace. There are different types of commercial insurance plans to choose from.
- **Deductible:** The amount you have to pay before your insurance begins to cover medical costs. For example, you could have a $1000 deductible per year before your health insurance will begin paying. It could take several doctor's visits or prescriptions to reach the deductible.
- **Explanation of Benefits (EOB):** Form generated by the insurance plan to explain how your claim was processed. This documents any patient responsibility that may be required.
- **Formulary:** List of drugs covered by your prescription benefit plan.
- **Government-funded health programs:** Health insurance benefits provided through programs funded by each state or the federal government, such as Medicare and Medicaid.
- **Health insurance marketplace (also called Health Insurance Exchange):** A government-sponsored resource where you can choose a health plan. It also provides information on programs that offer financial help for insurance coverage.
- **In-network provider:** Healthcare provider who is contracted with an insurance provider to provide care at a negotiated cost.
- **Medicare:** Insurance provided by federal government for people over 65 or people under 65 with certain disabilities or end-stage kidney disease.
- **Medicaid:** Insurance coverage for low-income families or patients with disabilities that is funded by federal and state governments and administered by states.
- **Out-of-network:** A provider that does not have a contract with the insurance carrier. If you use an out-of-network provider, you may be responsible for a greater portion of the charges or have to pay all the charges.
- **Out-of-pocket (OOP) cost:** The amount you may have to pay for covered healthcare services over the course of a year. The portion you pay may include your plan's deductible, copays, and/or coinsurance.
- **Out-of-pocket maximum (OOP):** The maximum amount you have to pay under your insurance policy (usually a 1-year period). When this maximum limit is reached, the insurance typically then pays 100% of eligible expenses. These out-of-pocket maximums can apply to all coverage or to a specific benefit category such as prescriptions.
- **Premium:** The amount you and/or your employer pays (usually monthly) to the health insurance company for coverage.
- **Primary care provider (PCP):** A healthcare professional that provides care and coordinates your access to a wide range of healthcare services. Certain plans require you to designate a primary care provider.
- **Prior authorization:** Authorization your provider may need to get from the insurance plan prior to providing certain types of treatment, medications, test, or procedures.
- **Provider network:** A group of healthcare providers (eg, doctors), facilities (eg, hospitals), and suppliers (eg, pharmacies) that work with an insurer to provide services and products to its members.
- **Referral:** Authorization that you may need to get from your primary care doctor in order to get health insurance coverage for specialty care (eg, a specialist).

How your CareconnectPSS team will support you

CareConnectPSS — Personalized support services for patients

CareConnectPSS®, personalized support services for patients, represents Sanofi Genzyme's more than 35-year commitment to supporting the rare disease community. CareConnectPSS is designed to support each patient's unique journey.

Our range of support to help patients living with a rare disease includes:

- Programs such as the Copay Assistance Program and Charitable Access Program for eligible patients
- Disease-specific information, including genetic education
- Care coordination for treatment
- Dedicated CareConnectPSS Patient Education Liaisons and Case Managers

Depending on your individual needs, your CareConnectPSS Team of experts can assist with the following:

Your **Case Manager** offers expertise in health insurance, navigating the health care system, facilitating transitions which may impact your access to insurance or treatment, and can assist you in identifying resources to help manage out of pocket costs related to your treatment.

Your **Patient Education Liaison** can help educate you, your family, friends, teachers, or employers about your disease.

To learn more about our range of support offerings, or to reach your existing CareConnectPSS Case Manager:
Call **1-800-745-4447 (Option 3)**
Email us at **Info@CareConnectPSS.com**
Visit **www.careconnectpss.com**

Additional resources

For more information on Marketplace insurance, visit **www.healthcare.gov.**
For more information on Medicare, visit **www.medicare.gov.**
For more information on COBRA, visit **www.dol.gov**
Talk to your employer's human resource department or office administrator.
Visit your state's department of insurance website.

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BY YOUR SIDE

through your journey with a rare disease

JUST A PHONE CALL OR EMAIL AWAY

Whether your needs are large or small, your CareConnectPSS team will work closely with you and your family to ensure you receive the confidential and personalized support you need. To learn more about our range of support offerings, or to reach your CareConnectPSS Case Manager, please call **1-800-745-4447**, and select **Option 3**, or email us at **Info@CareConnectPSS.com.**

For more information, visit us at **www.CareConnectPSS.com.**

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