HELPFUL TERMS

FINANCIAL AND INSURANCE GLOSSARY

Staying informed never goes out of style.

VUMERITY® (diroximel fumarate) delayed-release capsules 231 mg

This guide offers a list of definitions to help you stay up to date about common financial and insurance terms you may see while discussing your coverage for VUMERITY® (diroximel fumarate). If you need additional support, **Biogen Support Services** is here to help!

APPEAL:
A request for a health insurance plan to reconsider its decision to deny coverage for a specific healthcare service or product.

BENEFITS INVESTIGATION:
The research that is done to see if your health insurance plan covers a specific medicine.

CLAIM:
A request by your doctor that's sent to your insurance company to pay for the cost of services from a doctor's visit or a prescription.

COINSURANCE:
Your share of the costs for a covered healthcare service, calculated as a percent (for example, 20 percent). Your health insurance plan pays the balance of the allowed amount.

COPAY (COPAYMENT):
A fixed amount that you pay out of pocket for healthcare visits or prescriptions. Your health insurance plan pays the remaining costs.

COST SHARING:
Payment method in which you are required to pay for some of your healthcare costs, including deductibles, coinsurance, and copayments.

DEDUCTIBLE:
A dollar amount that you must pay each year before your health insurance plan will provide coverage. After you pay this amount, you usually only pay a copayment for services covered by your health insurance plan.

DENIAL:
When your health insurance company notifies you that it will not cover the cost of your medication or treatment.

DUAL ELIGIBLE:
A person who is eligible for both Medicaid and Medicare.

FEE-FOR-SERVICE (FFS):
A type of health insurance plan in which health-care providers are reimbursed by insurance companies based on each service provided. These plans give you more flexibility in choosing doctors or hospitals, but they tend to cost more. FFS is also known as indemnity insurance.

FLEXIBLE SPENDING ACCOUNT (FSA):
An account you set up through your job to help pay for healthcare costs. You don't pay taxes on this money. But if you don't spend all of your FSA money by the end of the year, you lose the money left.

GOVERNMENT-FUNDED HEALTH INSURANCE:
Health insurance benefits provided through programs funded by each state or the federal government, such as Medicare, Medicaid, TRICARE®, or the DoD/VA.

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HEALTH INSURANCE MARKETPLACE:
A government-sponsored resource where you can choose a health insurance plan. It also provides information on programs that offer financial help for insurance coverage. See more information at **healthcare.gov**.

HEALTH MAINTENANCE ORGANIZATION (HMO):
A type of health insurance plan in which you get care from a network of providers. Your primary care doctor coordinates all of your care.

HEALTH SAVINGS ACCOUNT (HSA):
An account you set up with your employer to save money for medical expenses. Like an FSA, you don't have to pay taxes on this money. Unlike an FSA, money can be carried over to the next year if you don't use it.

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP):
A type of health insurance plan with a higher deductible than a traditional one. The monthly premium is usually lower, but you pay more healthcare costs yourself before the insurance company pays its share (your deductible).

IN-NETWORK:
Doctors, hospitals, or other providers who participate in the health insurance plan you choose. You usually pay less when using an in-network provider. Some plans only pay for services when the member uses in-network providers. Other plans will pay some of the cost even if the member uses an out-of-network provider.

LETTER OF MEDICAL NECESSITY:
A letter submitted by your doctor to your health insurance plan that provides information to show that the requested healthcare services or supplies are needed to prevent, diagnose, or treat an illness, injury, condition, or disease.

MEDICAID:
A joint federal and state health insurance program that can help cover medical costs for people with limited income and resources. This can include adults, children, pregnant women, the elderly, and people with disabilities.

MEDICAL EXCEPTION (ME):
A request to use a drug due to your individual situation, even though your health insurance plan does not cover the drug.

MEDICARE:
A government health insurance program that provides coverage for individuals aged 65 years or older and for those younger than 65 years with certain disabilities.

MEDICARE'S PART D LOW INCOME SUBSIDY (LIS/EXTRA HELP):
Helps to cover prescription drug plan costs for people who meet certain asset and income requirements. Eligible people pay between $0-$10.35 for brand-name prescriptions.

OPEN ENROLLMENT:
A set time during which people can choose to make changes in their insurance coverage for the coming year.

OUT-OF-NETWORK:
Doctors, hospitals, or other providers not part of the health insurance plan you choose. You will pay more for these services. You also may need to pay all out-of-pocket costs if the healthcare provider is not in-network.

OUT-OF-POCKET (OOP) AND OUT-OF-POCKET MAXIMUM:
The money you pay for your healthcare costs out of your pocket. Your insurance company does not pay back this amount. The OOP maximum is the most you will have to pay during your policy period (usually 1 year). After you reach that limit, your health insurance plan covers all the costs.

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PAYER:
An organization that reimburses or pays for the cost of healthcare services. Examples of payers include commercial or government-funded health insurance plans, self-insured employers, and uninsured patients.

POINT-OF-SERVICE (POS) PLAN:
A health insurance plan that coordinates care with a primary care doctor. It allows more flexibility in choosing doctors and hospitals than an HMO.

PREFERRED PROVIDER ORGANIZATION (PPO):
A health insurance plan that contracts doctors and hospitals to create a network of providers. You can get care outside of the network, but will pay less if you use in-network providers.

PREMIUM:
A set amount, often paid monthly, to a health insurance plan for providing healthcare coverage.

PRIMARY CARE PHYSICIAN (PCP):
A physician (MD – Medical Doctor or DO – Doctor of Osteopathic Medicine) who provides or coordinates a range of your healthcare services.

PRIOR AUTHORIZATION (PA):
The requirement by a health insurance plan that, before coverage is allowed, a treatment or medication must be medically necessary.

PRIVATE (COMMERCIAL) HEALTH INSURANCE PLAN:
Any health insurance plan not run by the federal or state government. Examples of private health insurance plans include employer-sponsored plans and health insurance plans available through the Health Insurance Marketplace.

REAUTHORIZATION:
Helps ensure you can continue receiving your current medication after a certain period of time. (Sometimes, this is referred to as a "renewal of authorization.") It's often used to confirm that your treatment is still medically necessary and you've been successfully taking your medication. Reauthorization is fairly common with specialty medications, such as VUMERITY.

SPECIALTY DRUG:
High-cost drugs that treat serious, chronic diseases and require additional education from a healthcare professional. This can include drugs that are injected, infused, inhaled, or taken by mouth.

SPECIALTY PHARMACY:
A pharmacy for drugs that cannot be stocked in retail pharmacies due to storage and shipping requirements or the need for additional support required by healthcare professionals.

STEP THERAPY:
When you are required to start treatment for your condition using the most cost-effective and safe drugs before you can be prescribed similar drugs.

SUMMARY OF BENEFITS (OR EXPLANATION OF BENEFITS):
A document that describes what costs your health insurance plan will cover for healthcare services you received and allows you to compare the costs and coverage between different health insurance plans.

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