Eisai Patient Support

Understanding Health Insurance Coverage— A Patient's Guide

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 some questions you may consider when comparing your health insurance options.

Please note that the information in this guide is not exhaustive and is subject to change. Insurance coverage varies by health plan, patient, and setting of care.

Table of Contents

See the definitions for **bold** words at the bottom of each corresponding page or refer to the glossary on pages 18 and 19.

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.

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 you are prescribed. 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, through employers, unions, and trade organizations
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.	Typically, coverage is based on the benefits package provided by employer
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	Everyone, including those who are 65 years and older

See pages 4-16 for additional coverage information.

During Open Enrollment, you are allowed to make changes to your Medicare coverage plans.

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 and hospital visits as well as your prescriptions.

When considering Medicare coverage, it is important to note that there are 4 parts of Medicare (Parts A, B, C, and D).

Medicare Parts A and B (Original Medicare) are provided by the federal government and may not cover all of your medical needs. If you need prescription drugs or routine vision, dental, or hearing care, you may want to consider additional coverage options. **Medicare Supplemental Insurance (Medigap)** fills in the gaps, such as **deductibles** or **coinsurances**, of Original Medicare.

Medicare Part C and D are offered through private insurers and private companies, respectively.

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 doctors visits and visits to treatment centers for infusion or injections, some home health services, medical equipment, wellness services, lab tests, and select preventative services • Requires you to pay premiums, **copays** and deductibles, like private insurance companies would
C **Medicare Advantage**	• Coverage plans sold by private insurance companies that are approved by Medicare. These plans include all services covered under Part A and B with the option of prescription drug coverage • Can offer additional benefits such as dental, vision, and hearing
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.

DEFINITIONS:

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).

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

Coinsurance: A percentage of the total cost of care.

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.

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

Medicare Coverage:

Cost

What you pay for Medicare will be based on what coverage and services you get, and what **providers** you visit. You should know that 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).

Speak to your healthcare team about costs regarding your treatments and medicines. This will help you to choose the best Medicare plan 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. You'll pay either **$278** or **$505** each month for Part A, depending on how long you or your spouse worked and paid Medicare taxes	• **$1,632** for each **inpatient** hospital benefit period before Original Medicare (Parts A and B) starts to pay • For more information about benefit period, visit www.medicare.gov/basics/costs
B **Medical Insurance**	• **$174.70 or higher** depending on income per month, even if you don't get any Part B-covered services • This amount can change each year	• **$240** before Original Medicare starts to pay. You must meet this deductible once each year
C **Medicare Advantage**	• **Varies by plan**; these amounts can change each year	• **Varies by plan and pharmacy**. Visit, www.medicare.gov/compare-plan 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/compare-plan to compare costs and coverage of drug plans in your area

The information listed above is accurate for the 2024 coverage year as of October 12, 2023. Please visit https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles for the most up-to-date information.

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

DEFINITIONS:

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.

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.

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

Cost examples

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

When it comes to paying for your Medicare coverage, the first thing you will pay for is your monthly premium. As we covered earlier, a **premium** is the amount you might pay monthly for healthcare coverage paid for health insurance.

Beyond your premium, you will also have to pay towards 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 example show you two patients with different deductibles and how copays and coinsurances work in these instances.

Understanding copays

Amy has a deductible of **$600**

Amy pays that deductible off within the first 3 months of the year

Amy, now only pays her $15 copay because her deductible has been paid in full

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 only pay for 80% of costs

20%

Chris is now responsible for paying a 20% coinsurance

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

Medicare Coverage:

Medicare Open Enrollment

What is Open Enrollment?

Medicare Open Enrollment is a time when you can make changes to your health or drug coverage plan for the upcoming year. Open enrollment is your chance to review your current health insurance coverage and evaluate whether it still meets your needs.

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 health 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 health 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.

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

Medicare Coverage:

Medicare Supplemental Insurance (Medigap) and Extra Help Benefit

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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 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. It doesn’t repeat every year, like the Medicare Open Enrollment Period.

Extra Help Benefit

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 have low income or have limited assets, including in your checking or savings account.

What can the Extra Help Benefit offer me?

Extra Help can offer:

- Zero-cost or low-cost initial deductible and monthly premiums
- Lower out-of-pocket costs for brand-name 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 the Extra Help Benefit?

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 but are eligible for Medicaid as well (dual eligibility)
- Get help from Medicaid to pay for Part B
- Get Supplemental Security Income benefits

DEFINITION:

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.

There are 2 ways to sign up for Medicare

Sign up by telephone by calling **1-800-MEDICARE (1-800-663-4227)** 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**

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**.

Understanding your Explanation of Benefits (EOB) and a 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 Medicare Part A– and Part B–covered services.

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 over-paying 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.

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	Co Pay	Deductible	Coinsurance	Paid by Insurer	What You Owe	Remark Code
1	3/20/23-3/20/23	Medical care	Paid	$31.60	$2.15	$0.00	$0.00	$0.00	$2.15	$0.00	PDC
2	3/20/23-3/20/23	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.

DEFINITIONS:

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.

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

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.

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

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 all 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 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

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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 **www.medicaid.gov/about-us/beneficiary-resources**

Fill out an application through the **Health Insurance Marketplace** at **www.healthcare.gov**

DEFINITION:

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

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.

Commercial health insurance

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.

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.

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
- 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 find you are eligible for premium tax credit subsidies and other cost-sharing reductions.

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

The Affordable Care Act vs Medicaid and Medicare

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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 and Medicare?

	ACA	MEDICAID	MEDICARE
Basics	• Provides basic coverage requirements for all Americans and sets standards for required coverages offered by health care plans	• Government-funded social welfare program that provides free or low-cost coverage to low-income Americans	• Insurance provided by the federal government for people aged 65 years or older or that have a qualifying disability
Enrollment	• Enrollment is only open annually from November 1 to December 15	• Annual open enrollment is from October 15 to December 7. Although this is the primary time when you, a person with Medicaid, can choose a plan, there are other limited circumstances where you may be eligible to change your enrollment outside of the Medicare Open Enrollment Period	• Annual open enrollment is from October 15 to December 7. Although this is the primary time when you, a person with Medicare, can choose a plan, there are other limited circumstances where you may be eligible to change your enrollment outside of the Medicare Open Enrollment Period
Costs	• Plans are often coupled with significant payments from beneficiaries to receive care	• Medicaid requires little or no payments by means of copays, deductibles, etc	• Medicare cost is based on the coverage and services you get

DEFINITIONS:

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.

Managed care plan: Plans that include a network of doctors, hospitals, and other providers to coordinate care.

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

Frequently asked questions about the ACA

How do I qualify for the ACA?

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 jailed
- Are not covered by Medicare

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
- Preventive 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, and 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 learning more about your therapy and support. 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.

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.

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.

Coinsurance: A percentage of the total cost of care.

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.

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 you 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.

Glossary (cont'd)

Medicaid: A federal and state health insurance program that provides healthcare 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 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.

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.

Prior authorization: Approval that a health plan may require prior to covering a treatment or prescription.

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: Health 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.

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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