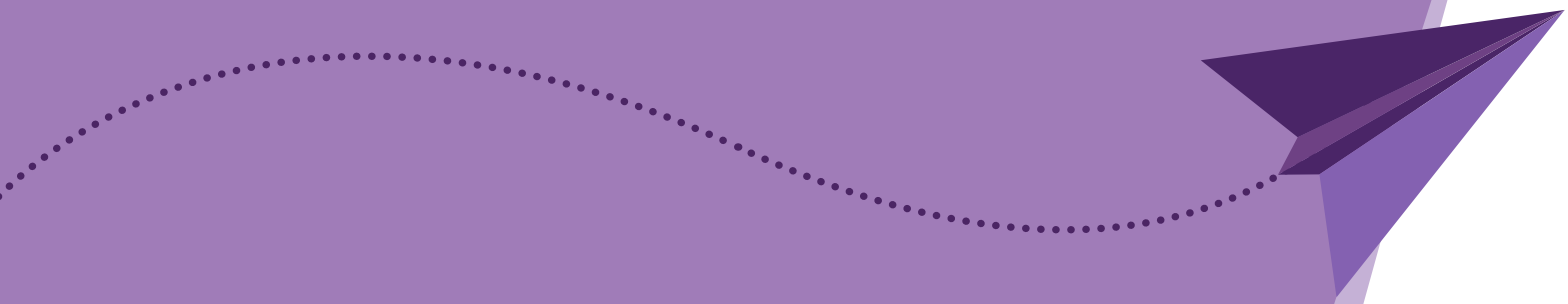
INSURANCE 101

A GUIDE TO NAVIGATING PLANS AND COVERAGE OPTIONS



VERTEX GPS™
GUIDANCE & PATIENT SUPPORT

WE'RE WITH YOU ALL THE WAY

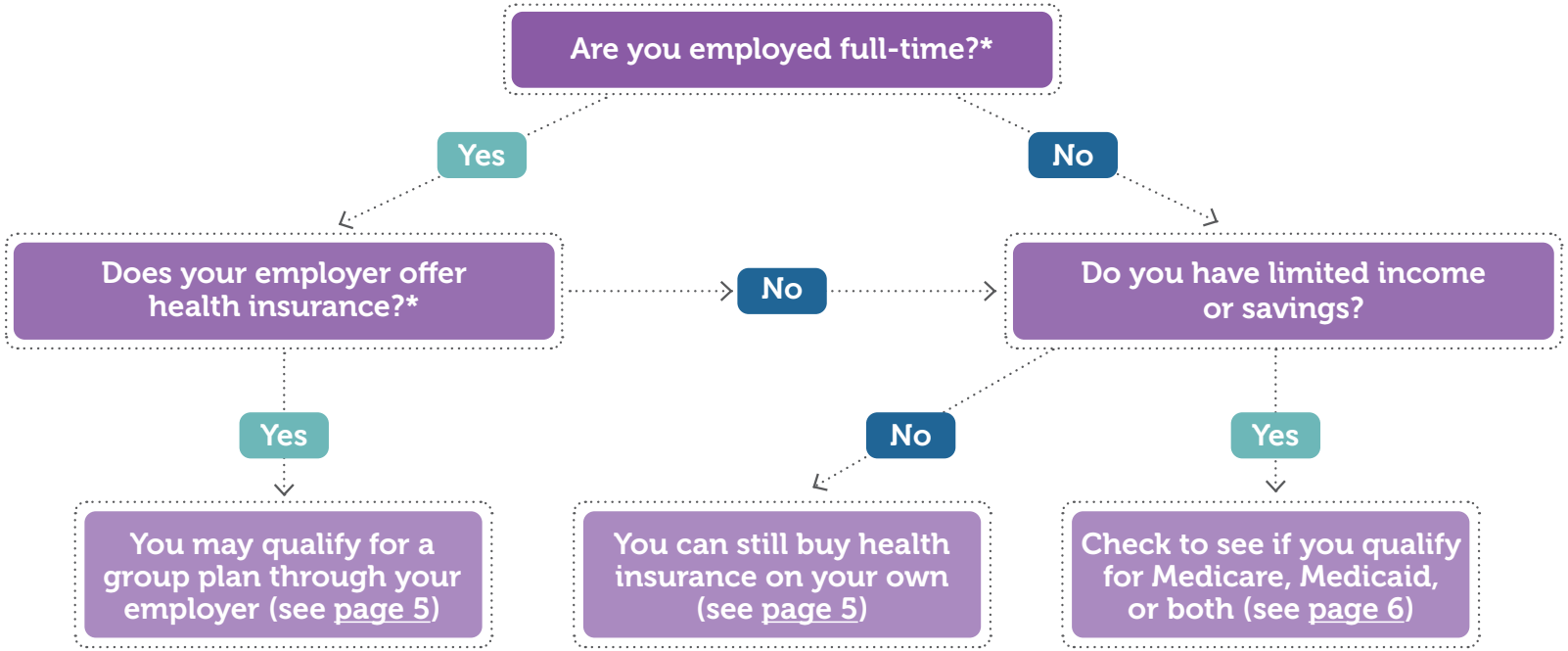
IN THIS GUIDE, YOU'LL FIND:

Sorting through health insurance can be complex, and the policies and programs always seem to be changing. While you may not be eligible for every plan, it is important to understand the options you are eligible for so you can decide which plan works best for you. Use this resource as a guide to navigate the different insurance options you may be considering.

TYPES OF HEALTH INSURANCE

Commercial and government-funded

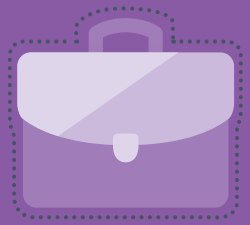
To get started, use these questions to see which type might be right for you. You can learn more about each type of health insurance on pages 4-11.



*Keep in mind that you may be eligible to receive commercial insurance through the employer of your spouse or domestic partner.

TYPES OF HEALTH INSURANCE

Commercial insurance: Group plans & individual plans



Commercial health insurance is coverage that is not provided by a government agency. Common types of commercial health insurance plans include preferred provider organizations (**PPOs**) and health maintenance organizations (**HMOs**).

See the glossary on pages 26-31 for definitions of HMO, PPO, and other insurance terms marked in bold and underlined throughout this resource.

Group plans

Q: Are you employed full-time?

A: Some employers might offer a group plan.

With a group plan, coverage is provided through an employer or a union.

Individual plans

Q: What can you do if you don't have insurance through your employer?

A: You can buy insurance on your own.

With individual plans, you purchase coverage directly from a private insurer or through the Health Insurance Marketplace (sometimes called the Health Insurance Exchange).

- The Marketplace, created as part of the Affordable Care Act, provides coverage to people who don't have access to a group-based plan, and who don't qualify for Medicare or Medicaid
- Before you purchase an individual plan, check to see if you qualify for Medicaid or Medicare

Visit HealthCare.gov for more detailed information about Marketplace plans.

TYPES OF HEALTH INSURANCE

Government-funded insurance: Medicare, Medicaid, and dual eligibility

People who qualify for government-funded health insurance have some or all of their healthcare costs paid for by the government. Medicare and Medicaid are 2 types of government-funded insurance.

For more information about government-funded insurance, visit Medicare.gov and Medicaid.gov.

Medicare

Q: Could Medicare be an option for you?

A: Yes, if you are age 65 or older or disabled.

Medicare is the federal health insurance program for people who are 65 years or older, certain younger people with disabilities, and people with end-stage renal disease.

If you are eligible, Medicare offers different types of coverage for specific services:

- **Part A: Hospital Insurance Coverage**—covers services such as hospital stays and home healthcare
- **Part B: Medical Insurance Coverage**—covers doctor visits, lab tests, X-rays, medical equipment, and emergency department (ED) visits
- **Part C: Medicare Advantage**—combines all benefits and services listed under Parts A, B, and usually D
- **Part D: Prescription Drug Plan** (also known as the Medicare Prescription Drug Plan or PDP)—helps cover prescription medicine costs, including shots and vaccines

(Medicare continued)

When you first sign up for Medicare, and during certain times of the year, you'll have different plan options to choose from:

Original Medicare

Original Medicare includes Part A (Hospital Insurance) and Part B (Medical Insurance). With both of these offerings, you can usually use any doctor or hospital that takes Medicare, anywhere in the US.

This plan does not cover prescription drugs, so if you choose Original Medicare, adding Part D (Prescription Drug Coverage) is important. Each Part D offering can vary in cost and specific drugs covered. The list of drugs covered is called a "**formulary**." Part D coverage has its own formulary where drugs are placed into different levels called "tiers." It is important to find out if the prescription drugs you take are covered.

You can also buy supplemental coverage from a private company to help pay for certain costs that are not covered by Medicare Parts A and B. One example is Medigap, which can help pay for your **out-of-pocket costs**.

If you have questions about your Medicare options, visit www.Medicare.gov/talk-to-someone. You can also visit the State Health Insurance Assistance Program (SHIP) website at www.shiphelp.org to find local Medicare assistance near you.

Medicare Advantage (also known as Part C)

Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D. Each Medicare Advantage plan can charge different out-of-pocket costs, can have different rules for how you get services, and can provide different benefits that Original Medicare doesn't cover—like vision, hearing, and dental services. In most cases, you'll need to use doctors who are in the plan's network.

Medicare Extra Help

Medicare Extra Help is a program that helps people who are on Medicare (who have Part D and qualify) with paying for their monthly **premiums**, annual **deductibles**, and **co-payments** related to Medicare prescription drug coverage.

Medicaid

Q: Could Medicaid be an option for you?

A: Yes, if you have limited income or savings.

Medicaid is a joint federal and state program that helps with medical costs for some low-income adults, children, pregnant people, elderly people, and people with disabilities. It covers:

- Free or low-cost healthcare for low-income individuals who qualify
- Inpatient and outpatient hospital services, doctor visits, home health services, and lab and X-ray services
- Prescription drugs

Be sure to check out your state's eligibility guidelines for Medicaid before buying an individual plan. Keep in mind that some states may place limits on medicines.

Dual eligibility

Q: Can you qualify for both Medicare and Medicaid?

A: Some people may qualify for both, meaning they are dual-eligible.

People who are dual-eligible are enrolled in both Medicare and Medicaid at the same time. Dual eligibility allows for more comprehensive coverage and typically applies to those with significant medical needs.

Medicaid does not pay for services covered under Medicare. Medicaid coverage only goes into effect after Medicare and other health insurance plans have been applied.

For more information about government-funded insurance, visit Medicare.gov and Medicaid.gov.

CHOOSING INSURANCE

And programs that can impact your out-of-pocket expenses

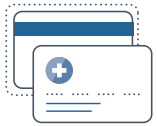
Research coverage

Each plan has different health and prescription drug benefits and restrictions, so it's important to do your research to ensure your health needs are covered.

It's a good idea to call each insurance plan to confirm the following:

- Are preferred doctors, specialists, emergency care, and hospital admissions covered?
- Are your prescriptions covered?
- Does the plan cover generic, brand, and specialty drugs?
- Are **prior authorizations** needed?

Look at out-of-pocket expenses



Deductibles, premiums, and other expenses can impact your overall healthcare costs. Your plan's **Summary of Benefits and Coverage (SBC)** will detail your benefits and how they are calculated.

Here are some initial steps you can take to better understand what your out-of-pocket costs may look like:

- Check if starting or renewing coverage will impact out-of-pocket costs. (For example, will prescription drugs cost more at the beginning of the year until your **out-of-pocket limit** is met?)
- Find out what the annual limit is on out-of-pocket expenses
- If your out-of-pocket expenses are met, will the plan cover 100% of expenses?
- Are the medicines you take to manage your cystic fibrosis (CF) classified as **essential health benefits**?
- How is manufacturer **co-pay assistance** applied towards your deductible and out-of-pocket limit?

Use the worksheet on pages 21-22 to help estimate what your out-of-pocket costs may be for the year to avoid surprises.

Essential health benefits

When comparing insurance plans and calculating potential costs, it's important to find out about a plan's maximum out-of-pocket costs and what they classify as essential health benefits. **The ACA limit on out-of-pocket costs can be found on HealthCare.gov.**

INSURANCE PROGRAMS THAT CAN IMPACT COVERAGE

Co-pay adjustment programs and Alternative Funding Programs

Be informed and prepared

In recent years, certain programs have been introduced that impact insurance coverage of specialty medications and their out-of-pocket costs for patients. These programs are known as **co-pay adjustment programs** and **Alternative Funding Programs (AFPs)**.

Understanding co-pay adjustment programs

Co-pay adjustment programs prevent manufacturer co-pay assistance from counting toward your annual deductibles, out-of-pocket costs, and/or **out-of-pocket maximums**. "Accumulators" and "maximizers" are examples of co-pay adjustment programs that can result in changes to your out-of-pocket expenses for your specialty medicines and other healthcare costs.

If you rely on manufacturer co-pay assistance programs, it is important to understand if your insurance plan uses one of these co-pay adjustment programs and assess how you may be affected.

These programs are not always easy to identify, and they can have names such as:

- Accumulator Adjustment Program
- Variable Co-pay Program
- Coupon Adjustment: Benefit Protection Program
- Out-of-Pocket Protection Program

Tips to help you identify co-pay adjustment programs

- Reach out to your insurance provider or human resources representative for your plan's Summary of Benefits and Coverage (SBC), which will include all benefit details and how they are calculated so you know what costs to expect
- Within the SBC, **exclusions and limitations** will be listed. Search for keywords, such as *coupon*, *co-pay card*, *manufacturer*, and *discount*, to determine if there are any written restrictions for the co-pay assistance you may receive. **Your Vertex GPS Support Specialist can review the SBC with you to help you identify the use of a co-pay adjustment program**
- Once you review the SBC, you should call your health insurance plan and ask them directly how manufacturer co-pay assistance is applied or accepted

Remember, it's your right to know and understand what services are covered through your health insurance plan. Insurance companies, employers, and plan sponsors must provide you with the plan's SBC and a glossary of terms used in your coverage when you apply for or renew your policy. The SBC must also be provided to you at any time upon your request.

Find a dedicated insurance representative to support you

It can help to make a connection with a particular person within your insurance company and have their name and direct phone number on hand. Having a relationship with a dedicated contact can help you get your questions answered and may help you resolve issues more quickly.

Understanding Alternative Funding Programs

Drug manufacturers and third-party organizations sometimes offer **Patient Assistance Programs (PAPs)**, commonly called free drug programs, to support people who are uninsured or underinsured. The assistance provided through these programs is intended for those with unmet coverage needs.

Some employers and plan sponsors are now using **Alternative Funding Programs** (**AFPs**, also known as specialty carve-outs).

When an AFP is used, specialty medicines like your Vertex medicine can be excluded from your insurance plan's formulary (or drug list). This can make you appear to be uninsured or underinsured despite having coverage. In doing this, the AFP is attempting to manipulate insurance benefits to make you appear eligible for assistance through a PAP.

Understanding AFPs (continued)

As a result of an AFP, you could be forced to seek "alternative" coverage for your medicine through:

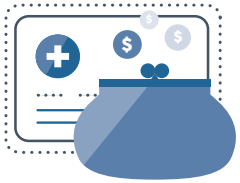
- Funding from third-party charitable organizations
- Manufacturer Patient Assistance Programs (PAPs), which are meant to be an option only for those who are truly uninsured or have unmet coverage needs

Employers and plan sponsors that use AFPs often do so for potential cost savings, without fully understanding the impact on patients. Exploring alternative options and negotiating coverage can be stressful, time-consuming, and can cause treatment delays as there is no guarantee of alternative coverage. Manufacturers and charitable organizations have eligibility requirements and are limited in terms of how much assistance they are able to provide.

We're here to help

AFPs work as gatekeepers to accessing the health insurance coverage patients are entitled to. Your Vertex GPS™ Support Specialist can help you navigate these programs by reviewing your plan's SBC with you to determine if an AFP is involved.

How do co-pay adjustment programs and AFPs differ from one another?



Co-pay adjustment programs are used within certain health insurance plans, while **Alternative Funding Programs (AFPs)** are separate from health insurance; AFP providers are hired by employers and other plan sponsors who offer health insurance.

Co-pay adjustment programs often provide coverage for specialty medicines. However, they do not count manufacturer co-pay assistance towards your deductible and/or out-of-pocket maximum. Therefore, you are responsible for any costs toward those limits before your insurance plan will cover the specialty medicines.

AFPs instead eliminate any coverage you may have for specialty medicines. This places the full cost responsibility on you if you are unable to obtain alternative funding from other assistance options.

It's important to be aware of these programs and the harmful impact they can have on your insurance coverage.

Reach out to your Vertex GPS™ Support Specialist for additional information.

Important questions to ask about your health insurance plan

Here are some questions you can ask a representative to help you learn more about your current plan or a plan you are considering. Answers to these questions will help you get a better idea of what is covered through your plan and help you confirm if there are any practices at play (like co-pay adjustment programs or AFPs) that could impact your out-of-pocket cost responsibilities.

- What plan options are available to me?
- How is my current list of medicines covered? (Make sure they have a complete and up-to-date list.)
- Do my medicines require a co-pay or co-insurance?
- Is my Vertex medicine included on my plan's formulary?
- Are any of my medicines considered nonessential?
- Are specialty medicines covered under my plan?
- Is an Alternative Funding Program (or specialty carve-out program) used with my coverage?
- Does the cost of medicines count towards my deductible?
- If I'm in a co-pay adjustment program, how does this impact my out-of-pocket costs?
- Can you provide me with a Summary of Benefits and Coverage (SBC) for my plan?

COMPARING INSURANCE PLANS

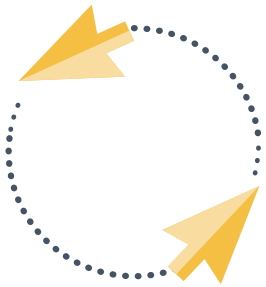
Whether you're thinking about changing your existing plan or joining one for the first time, use this worksheet to help you make the decision.

Plan information	Option 1 ($ per month)		Option 2 ($ per month)	
Premium: individual				
Premium: family or individual +1				
Annual cost	**In-network ($ per year)**	**Out-of-network ($ per year)**	**In-network ($ per year)**	**Out-of-network ($ per year)**
Deductible: individual				
Deductible: family or individual +1				
Out-of-pocket maximum: individual				
Out-of-pocket maximum: family or individual +1				
Amount of co-pay assistance you receive				
Does co-pay assistance count towards deductible and/or out-of-pocket maximum? (Write down Yes or No)				

My current healthcare providers		Option 1		Option 2	
Type of doctor	Name of doctor	Covered (Y/N)	Co-pay/co-insurance ($ or % per visit)	Covered (Y/N)	Co-pay/co-insurance ($ or % per visit)
Primary care					
Pulmonologist					

My prescriptions	Prescription drug plan Option 1			Prescription drug plan Option 2		
Medicine name	Covered (Y/N)	Co-pay/ co-insurance ($ or % per fill)	Prior authorization required (Y/N)	Covered (Y/N)	Co-pay/ co-insurance ($ or % per fill)	Prior authorization required (Y/N)

Please note that Vertex GPS™ cannot help you compare plans or recommend plan selections. However, we can help review your current plan details. If you need assistance completing this worksheet or have any questions about a plan you are considering, please reach out to the health plan provider. See pages 26-31 for common insurance terms and definitions that you may find useful when completing the chart above.



UPDATING YOUR INSURANCE POLICY

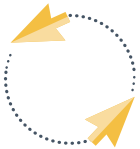
What to do after you change your plan

Get to know your insurance card

Once you've changed your plan, you will need to provide your new information to your care team. They may ask for your:

- **Member ID number:** This number is unique to you. It identifies you as an individual who is covered and allows you to access your benefits when you need care
- **Group number:** If you received insurance through an employer, a group number will also be listed on your card. This helps identify the benefits you receive through your employer's plan. Your care team may use this number to file **claims**

Tell your healthcare provider



Once you've changed insurance policies, let your CF center and other members of your healthcare team know about your switch.

Tell your Vertex GPS™ Support Specialist

Remember, if you make changes to your health plan, tell your Vertex GPS Support Specialist so that we can help you avoid any gaps in coverage for your treatment.

In addition, your eligibility for co-pay assistance from Vertex GPS and the amount of assistance we can provide may change based on your insurance choices. It is important to let us know right away if your insurance has changed.

Coordinate with your specialty pharmacy

Together with your Support Specialist, you should tell your **specialty pharmacy** about the change as soon as possible. Keep in mind that a change in insurance may also require a change of your specialty pharmacy, but your Support Specialist can help you navigate that transition if needed.

COVERAGE LOSS RELATED TO EMPLOYMENT

If you have recently lost your health insurance after leaving or losing your job, contact your Vertex GPS™ Support Specialist to talk about next steps.

Your Support Specialist can be reached via call or text at **1-877-752-5933 (press 2 when calling)**.

If you lose your employer-based coverage, you may have the following options:

- **Special enrollment period:** This allows you to enroll in an individual plan by purchasing it directly from the Health Insurance Marketplace. You usually have 60 days from the day you lose coverage to enroll
- **COBRA:** With COBRA, or the Consolidated Omnibus Budget Reconciliation Act, you have the option to continue the coverage you received from your former employer for a limited period of time
- **Medicare or Medicaid:** If you qualify for government-funded insurance, you can enroll in these programs at any time

Did you know?
If you are turning 26 and "aging out" of your parents' job-based health insurance coverage, you may qualify for purchase of temporary extended coverage for up to 36 months through COBRA. You may also be eligible for individual coverage purchased through the Health Insurance Marketplace during a special enrollment period within 60 days of aging out of your current plan. For more information or to enroll, visit **Healthcare.gov**.

GLOSSARY OF INSURANCE TERMS

Here are definitions for some common insurance terms.

Alternative Funding Programs (AFPs)

AFPs (also known as specialty carve-outs) work by excluding specialty medicines from your health plan's formulary. This can make you appear to be uninsured or underinsured, despite having coverage. These programs aim to get "alternative funding" for specialty medications with financial assistance offered through Patient Assistance Programs (PAPs) and other third-party charitable organizations.

Claim

This is a request for payment that you or your healthcare provider submits to your health insurance company after you receive a medical bill. The specific care or services you received must be covered under your plan in order for you to be reimbursed.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives individuals and families the right to continue health insurance coverage after a loss of group plan benefits. This can be due to losing or leaving your job, a change in how many hours you work, death, divorce, and other life events. If you qualify, you may be required to pay the entire premium for coverage up to 102% of the cost to the plan.

Coordination of benefits (COB)

Sometimes 2 insurance plans work together to pay claims for the same person. That process is called coordination of benefits. Insurance companies coordinate benefits to avoid duplicate payments, to establish which plan is primary and which plan is secondary, and to help reduce the cost of insurance premiums.

How does coordination of benefits work?
Let's say you have a child who is covered by your health insurance plan and your former spouse's plan. When your child goes to the doctor, your insurance company will review the claim to figure out which plan is primary and which plan is secondary. That's coordination of benefits.

Co-insurance

The percentage of covered medical expenses you pay after you've met your deductible. Your health insurance plan pays the rest.

- For example: If you have an "80/20" plan, it means your plan covers 80% and you pay 20%—up until you reach your maximum out-of-pocket limit

Co-pay

A set amount you pay (the patient responsibility), for your prescriptions, doctor visits, and other types of care. Typically, a co-pay is a flat dollar amount.

- For example: The cost of a prescription may be covered by insurance, but there will still be a co-pay that you need to pay at the pharmacy

Co-pay accumulator

A type of co-pay adjustment program that does not count co-pay assistance toward your deductible, out-of-pocket costs, and/or out-of-pocket maximum. Typically, manufacturer co-pay assistance funds prescriptions until the maximum value of the assistance is reached. After that, the patient's out-of-pocket costs begin counting toward their annual deductible and out-of-pocket maximum.

Co-pay adjustment programs

Programs that do not count co-pay assistance towards your deductible, out-of-pocket costs, and/or out-of-pocket maximum. This co-pay assistance includes co-pay cards and traditional coupons provided by manufacturers.

Co-pay assistance

This is money that a drug manufacturer may provide to patients to help with the co-pay costs of a prescription.

- For example: Many manufacturers offer this assistance in the form of co-pay cards or coupons

Co-pay maximizer

A type of co-pay adjustment program that does not count co-pay assistance towards your deductible and/or out-of-pocket maximum. Typically, the maximum value of the manufacturer's coupon/card is applied evenly throughout the benefit year.

Deductible

The amount you may have to pay for care or prescriptions before your insurance plan begins to pay.

How does a deductible work?

You see an out-of-network specialist twice a month for $100 a session. Your out-of-network deductible is $1,000. You will pay $100 for the first 10 sessions—until you reach $1,000. After you meet the $1,000 deductible, your specialist visits will be covered by your plan for the remaining calendar year.

Note: You may still be responsible for a co-pay after your deductible is met.

Essential Health Benefits

A set of 10 categories of services health insurance plans must cover under the Affordable Care Act.

Exclusion or limitation

This is the name of a specific drug or service that is not covered or has limited coverage due to location by your health insurance plan.

Exclusive provider organization (EPO)

This type of plan offers a limited network of providers to choose from. No referrals are required to see a specialist, but you need to confirm your treatment center is in-network before enrolling.

Explanation of Benefits (EOB)

This is a report or statement you receive from your insurance company that explains in detail how they paid your claim, according to the specific benefits described in your health plan.

Formulary

A formulary is a list of drugs covered by an insurance plan. There are various types:

- Open: little or no limitation on the medicines covered
- Restricted: some flexibility in choice of medicines
- Closed: coverage limited to only the medicines specified in the formulary

Fully insured plan

A plan in which the employer pays a certain amount each month (the premium) to the health insurance company. In return, the insurance company covers the costs of the employees' healthcare.

Health insurance network

This refers to the entire network of healthcare providers, suppliers, and facilities that your health insurance plan works with.

Health maintenance organization (HMO)

This type of healthcare plan limits coverage to healthcare providers contracted within the HMO network only. You will select a primary care physician (PCP), who must then give you a referral whenever you need to see any in-network specialists.

In-network co-pay/co-insurance

A fixed amount or percentage you pay for covered healthcare services to providers who are part of your health insurance plan's network. In-network co-pays/co-insurance usually cost less than out-of-network co-pays/co-insurance.

In-network provider

A healthcare provider who is contracted with the health insurance plan to provide care to policyholders for an agreed rate.

Managed care

A healthcare plan or system that seeks to control the quality and cost of medical services by contracting with a network of providers.

Open enrollment

Open enrollment is the annual period when you can sign up through your employer for a new health insurance plan, enroll in other benefit programs (such as a flexible spending account), or make changes to your existing plan.

Out-of-network co-pay/co-insurance

A fixed amount/percentage you pay for covered healthcare services to providers who do not contract with your health insurance or plan. Out-of-network co-pay/co-insurance usually costs more than in-network co-pay/co-insurance.

Out-of-network provider

A healthcare provider who is not under contract with your health insurance plan. When you get care from an out-of-network provider, your insurance company typically pays either less or nothing at all for the services you received.

Out-of-pocket costs

Costs that you have to pay on your own because they're not covered by your insurance plan.

- For example: If you elect to have a procedure that costs $1,000 and it's not covered by your plan, you will need to pay $1,000 yourself

Out-of-pocket limit or maximum

The most you pay during a policy period (usually per year) before your health insurance or plan pays for the full cost of covered benefits. Each plan is different; it's best to ask your insurance company what counts towards your out-of-pocket maximum.

Patient Assistance Programs (PAPs)

If you have prescription drug coverage but still need help paying for your medicine, many drug manufacturers offer free or low-cost brand-name medicines through Patient Assistance Programs or PAPs. To receive assistance from a PAP, you must first meet certain eligibility criteria to enroll in the program.

Pharmacy benefits manager (PBM)

A third party who works with insurance plans, drug manufacturers, and pharmacies to help manage prescription drug benefits and process prescription-related claims.

Preferred provider organization (PPO)

A type of healthcare plan that allows you to use providers both inside and outside of your network and get coverage for both. You will pay less for care from in-network providers.

Premium

The amount that must be paid for your health insurance or plan to keep your coverage active. This is usually paid monthly.

Prior authorization (PA)

You may need a prior authorization before you can receive your medicine. If required, your healthcare provider works with your pharmacy to provide this information. A PA may need to be renewed after a certain amount of time. So, it may help to keep an updated list of your medicines that require a PA so you know when renewals are needed.

Reimbursement

The process through which the insurance provider pays healthcare providers for their services.

Retail pharmacy

An independent, chain, supermarket, or mass-merchandiser pharmacy that is licensed to dispense medicines to the general public.

Self-insured plan

A type of insurance plan usually offered by larger companies where the employer collects premiums from people enrolled in the plan and manages payments.

Special enrollment period

A time outside the yearly open enrollment period when you can still sign up for health insurance. You qualify for a special enrollment period if you've had certain life events or unusual circumstances like having a baby, getting married, or losing your current insurance. You usually have up to 60 days following the event to enroll in a plan.

Specialty pharmacy

A specialty pharmacy fills prescriptions for certain drugs that are not available at retail pharmacies. Vertex medicines are only distributed through specialty pharmacies.

Summary of Benefits and Coverage (SBC)

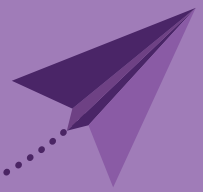
This is the section in your insurance policy that details your benefits and how they are calculated, including deductible, co-payment, coinsurance amounts, and out-of-pocket limits.

HAVE QUESTIONS?

Your Vertex GPS™ Support Specialist is here to help you find answers and get you the support you need.

Just call or text 1-877-752-5933 (press 2 when calling).
We're available Monday through Friday, 8:30 AM to 7 PM ET.

VertexGPS.com



VERTEX

Vertex and the Vertex triangle logo are registered trademarks of Vertex Pharmaceuticals Incorporated.
Vertex GPS is a trademark of Vertex Pharmaceuticals Incorporated.
© 2023 Vertex Pharmaceuticals Incorporated | VXR-US-20-1900061 (v5.0) | 09/2023