

Anthem Blue Cross CalPERS Exclusive Provider Organization EPO Monterey County

Coverage Period: 01/01/2017–12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com/ca/calpers or by calling 1-877-737-7776.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall deductible ? | For EPO/In-Network Providers: \$0 Member/ \$0 Family Non-EPO/Out-of Network Providers are not covered unless a medical emergency. | See the chart starting on page 2 for how much you pay for covered services after you meet the deductible . |
| Are there other deductibles for specific services? | No. | See the chart starting on page 2 for other costs for services this plan covers. |
| Is there an out-of-pocket limit on my expenses? | Yes. For EPO/In-Network Providers: \$1,500 Single / \$3,000 Family Non-EPO/Out-of Network Providers are not covered unless a medical emergency. For Pharmacy/Prescription Expenses: \$5,650 Individual/ \$11,300 Family Mail Order: \$1,000 | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services with participating providers. This limit helps you plan for health care expenses. |
| What is not included in the out-of-pocket limit ? | Balance-Billed Charges, Health Care This Plan Doesn't Cover, Premiums, Infertility Treatment costs, Unauthorized charges incurred for services and supplies from a Non-EPO/Out-of Network provider referral unless in connection with an emergency or urgent care. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Is there an overall annual limit on what the plan pays? | No | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits. |
| Does this plan use a network of providers ? | Yes. See www.anthem.com/ca/calpers for a list of Providers or call 1-877-737-7776. | If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network |

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| | | |
|---|--|--|
| | | <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| Do I need a referral to see a <u>specialist</u> ? | No, as long as the provider is on the list found at www.anthem.com/ca/calpers | You can see the <u>specialist</u> you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <u>excluded services</u> . |



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an EPO/ In-Network Provider | Your Cost If You Use a Non EPO/ Out-of-Network Provider | Limitations & Exceptions |
|---|--|--|---|--------------------------|
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$15 Copay/Visit | Not Covered 100% Out of Pocket | -----none----- |
| | Specialist visit | \$15 Copay/Visit | Not Covered 100% Out of Pocket | -----none----- |

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| Common Medical Event | Services You May Need | Your Cost If You Use an EPO/ In-Network Provider | Your Cost If You Use a Non EPO/ Out-of-Network Provider | Limitations & Exceptions |
|--|--|---|--|---|
| | Other practitioner office visit | <u>Chiropractic & Acupuncture</u> \$15 Copay/Visit | <u>Chiropractic & Acupuncture</u> Not Covered 100% Out of Pocket | <u>Chiropractic Care & Acupuncture Rider Plan</u> 20 Visits per calendar year combined for Chiropractic & Acupuncture. |
| | Preventive care/ screening /immunization | No Cost Share | Not Covered 100% Out of Pocket | -----none----- |
| If you have a test | Diagnostic test (x-ray, blood work) | <u>Lab & X-Ray-Office</u> No Cost Share | <u>Lab- & X-Ray-Office</u> Not Covered 100% Out of Pocket | -----none----- |
| | Imaging (CT/PET scans, MRIs) | No Cost Share | Not Covered 100% Out of Pocket | Subject to pre-service review to determine medical necessity. |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.optumrx.com/calpers or call 855-505-8110 | Generic drugs | \$5/30 day supply \$10/90 day supply | Not Covered 100% Out of Pocket | After second fill you will pay the appropriate mail service copay for maintenance medications. 90 day supplies (OptumRx Select90 Saver) allowed at Walgreens and Home Delivery program. |
| | Preferred brand drugs | \$20/30 day supply \$40/90 day supply | Not Covered 100% Out of Pocket | |
| | Non-preferred brand drugs | \$50/30 day supply \$100/90 day supply | Not Covered 100% Out of Pocket | |
| | Specialty drugs | Specialty follows the tier structure above | Not Covered 100% Out of Pocket | Certain Specialty Medications are available only through BriovaRx Specialty Pharmacy and are limited up to a 30-day supply. |

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|---|--|--|---|--|
| If you have outpatient surgery | Facility fee (e.g. Ambulatory Surgery Center; ASC) | No Cost Share | Not Covered 100% Out of Pocket | Subject to pre-service review to determine medical necessity. |
| | Physician/surgeon fees | No Cost Share | Not Covered 100% Out of Pocket | -----none----- |
| If you need immediate medical attention | Emergency room services | \$50 Copay/Visit | \$50 Copay/Visit | \$50 Copay waived if admitted Inpatient. This is for the hospital emergency room/facility charge only. The ER physician charge may be separate. |
| | Emergency medical transportation | No Cost Share | No Cost Share | Non EPO/Out of Network covered only if medical emergency. |
| | Urgent care | \$15 Copay/Visit | \$15 Copay/Visit | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Cost Share | Not Covered 100% Out of Pocket | Certain hospital services are subject to pre-service review to determine medical necessity. |
| | Physician/surgeon fee | No Cost Share | Not Covered 100% Out of Pocket | -----none----- |

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|---|--|--|--|---|
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | <u>Office Visit</u> \$15 Copay/Visit <u>Health Facility Visit-Facility Charges</u> No Cost Share | <u>Office Visit</u> Not Covered 100% Out of Pocket <u>Health Facility Visit-Facility Charges</u> Not Covered 100% Out of Pocket | -----none----- |
| | Mental/Behavioral health inpatient services | No Cost Share | Not Covered 100% Out of Pocket | This is for facility professional services only. Please refer to your hospital stay for facility fee. |
| | Substance use disorder outpatient services | <u>Office Visit</u> \$15 Copay/Visit <u>Facility Visit-Facility Charges</u> No Cost Share | <u>Office Visit</u> Not Covered 100% Out of Pocket <u>Facility Visit-Facility Charges</u> Not Covered 100% Out of Pocket | -----none----- |
| | Substance use disorder inpatient services | No Cost Share | Not Covered 100% Out of Pocket | This is for facility professional services only. Please refer to your hospital stay for facility fee. |
| If you are pregnant | Prenatal and postnatal care | No Cost Share | Not Covered 100% Out of Pocket | -----none----- |
| | Delivery and all inpatient services | No Cost Share | Not Covered 100% Out of Pocket | -----none----- |

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|---|---------------------------|--|---|--|
| If you need help recovering or have other special health needs | Home health care | No Cost Share | Not Covered 100% Out of Pocket | \$15 /visit for Physical therapy, occupational therapy, speech therapy, or respiratory therapy. Subject to pre-service review to determine medical necessity. |
| | Rehabilitation services | \$15 Copay/Visit | Not Covered 100% Out of Pocket | Copay applies to visits for rehabilitation, such as physical therapy, occupational therapy or speech therapy. |
| | Habilitation services | \$15 Copay/Visit | Not Covered 100% Out of Pocket | Copay applies to visits for rehabilitation, such as physical therapy, occupational therapy or speech therapy. |
| | Skilled nursing care | No Cost Share | Not Covered 100% Out of Pocket | Coverage is limited to 100 days/calendar year. Subject to pre-service review to determine medical |
| | Durable medical equipment | No Cost Share | Not Covered 100% Out of Pocket | Specific durable medical equipment is subject to pre-service review to determine medical necessity. |
| | Hospice service | No Cost Share | Not Covered 100% Out of Pocket | -----none----- |
| If your child needs dental or eye care | Eye exam | No Cost Share | Not Covered | -----none----- |
| | Glasses | Not Covered | Not Covered | -----none----- |
| | Dental check-up | Not Covered | Not Covered | -----none----- |

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot-care (unless you have been diagnosed with diabetes. Consult your formal contract of coverage)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Adult -Routine eye care (limited to one visit/benefit year)
- Bariatric surgery (For morbid obesity. Consult your formal contract of coverage)
- Hearing Aids (1 per ear/every 3 years)
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-877-737-7776. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross 1-855-839-4524 P.O. Box 60007 Los Angeles, CA 90060-0007 Attn: CalPERS Grievance and Appeal Management
Additionally, a consumer assistance program can help you file your appeal. Contact: California Department of Managed Health Care Help Center
980 9th Street, Suite 500 Sacramento, CA 95814
(888) 466-2219 <http://www.healthhelp.ca.gov> helpline@dmhc.ca.gov

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.”

This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).

This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwoł íínízínigo t'áá diné k'éjíggo, t'áá shoodí ba na'ałníhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'í hodiilní. Hai'daą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'í hodiilní.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mại của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,380
- Patient pays \$160

Sample care costs:

| | |
|----------------------------|----------------|
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital charges (baby) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$7,540 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$0 |
| Copays | \$15 |
| Coinsurance | \$0 |
| Limits or exclusions | \$150 |
| Total | \$160 |

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,970
- Patient pays \$430

Sample care costs:

| | |
|--------------------------------|----------------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$0 |
| Copays | \$350 |
| Coinsurance | \$0 |
| Limits or exclusions | \$80 |
| Total | \$430 |

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

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For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

A request for your health insurer or **plan** to review a decision or a **grievance** again.

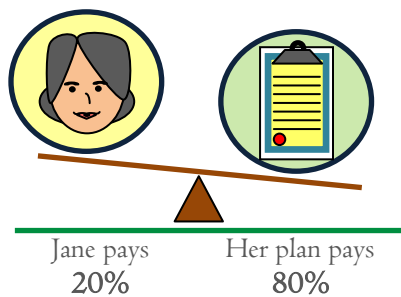
Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service.

You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



(See page 4 for a detailed example.)

Complications of Pregnancy

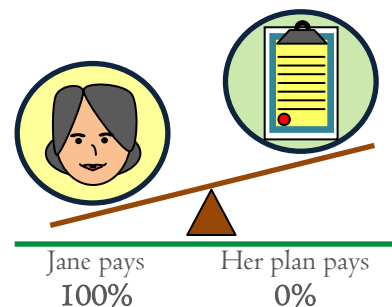
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance

A complaint that you communicate to your health insurer or **plan**.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care

Health care services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network

The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance

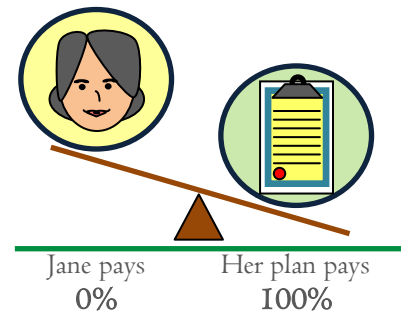
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization

A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage

Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

How You and Your Insurer Share Costs - Example

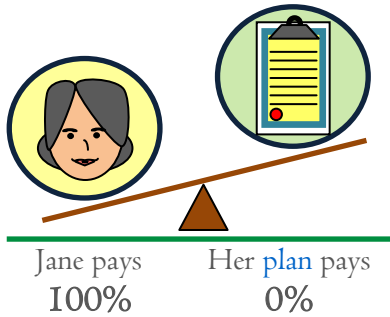
Jane's Plan Deductible: \$1,500

Co-insurance: 20%

Out-of-Pocket Limit: \$5,000

January 1st
Beginning of Coverage
Period

December 31st
End of Coverage Period



Jane hasn't reached her \$1,500 deductible yet

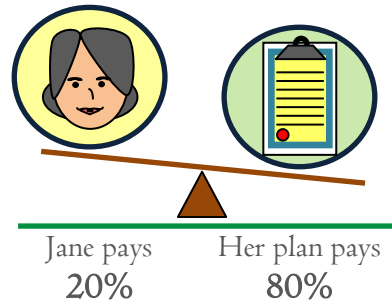
Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0

more costs



Jane reaches her \$1,500 deductible, co-insurance begins

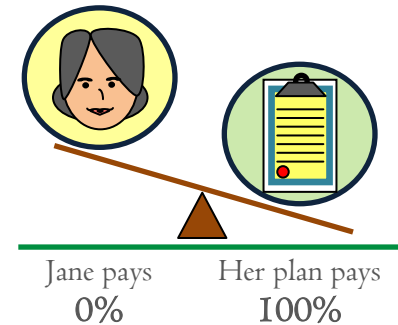
Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: \$75

Jane pays: 20% of \$75 = \$15

Her plan pays: 80% of \$75 = \$60

more costs



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$200

Jane pays: \$0

Her plan pays: \$200