Anthem Blue Cross
California Association of Highway Patrolmen (CAHP) Basic Plan

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:** PPO

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 or by calling 1-800-759-5758.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PPO Providers: **$0** Member/**$0** Family For Non-PPO Providers: **$0** Member/**$0** Family	Not applicable. See the chart starting on page 2 for your costs for services this plan covers.
Are there other Deductible's for specific services?	No	Not applicable. See the chart starting on page 2 for your costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For Medical Services/Expenses**: For Participating PPO Providers: **$2,000** Member/ **$4,000** Family For Non-PPO Providers no out-of-pocket limit when using a Non-PPO provider. **For Pharmacy/Prescription Drug Services:** **$5,150 Member/$10,300 Family**	The **out-of-pocket limit** is the most you could pay during a Calendar 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?	Non-participating providers, premiums, balance-billed charges and health care this plan doesn't cover.	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 specific coverage limits, such as limits on the number of visits.

Questions: Call 1-800-759-5758 or visit us at www.anthem.com/ca/calpers
If you aren't clear about any of the underlined terms used in this form, you can view the glossary at www.dol.gov/ebsa/pdf/sbcuniformglossary.pdf or call 1-800-759-5758 to request a copy.

Does this plan use a network of providers?	Yes. See www.anthem.com/ca/calpers for a list of participating providers.	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, our in-network doctor or hospital may use an out-of-network **provider** for some services. Plan uses the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** 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 10. See your policy or plan document for additional information about **excluded services**.

- **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 In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$15** Copay/Visit	**40%** Coinsurance	--------none--------
	Specialist visit	**$15** Copay/Visit	**40%** Coinsurance	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Other practitioner office visit	Chiropractor **10%** Coinsurance Acupuncturist **10%** Coinsurance	Chiropractor **40%** Coinsurance Acupuncturist **40%** Coinsurance	Benefits are limited to 20 visits per calendar year for any combined chiropractic or acupuncture service. An authorization is required for all physical and occupational therapy benefits in excess of 24 visits in a Year.
	Preventive care/ screening/ immunization	No Charge	**40%** Coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office **10%** Coinsurance X-Ray – Office **10%** Coinsurance	Lab – Office **40%** Coinsurance X-Ray – Office **40%** Coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	**10%** Coinsurance	**40%** Coinsurance	Prior authorization is required for PET scans. Contact Anthem Blue Cross at 1-800-274-7767 to initiate authorization. Services not preauthorized may not be covered.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	**$5** copay/30 day prescription supply at retail; **$10** copay/90 day prescription supply at mail order.	**100%** up-front cost; paper claim may be submitted to request partial reimbursement	After the second prescription drug fill at a retail pharmacy, the Member is responsible for a **$10** co-payment.
	Preferred Brand drugs	**$20** copay/30 day prescription supply at retail; **$40** copay/90 day prescription supply at mail order.	**100%** up-front cost; paper claim may be submitted to request partial reimbursement	After the second prescription drug fill at a retail pharmacy, the Member is responsible for a **$40** co-payment.
	Non-Preferred Brand drugs	**$25** copay/30 day prescription supply at retail; **$50** copay/90 day prescription supply at mail order. In addition to the copay amount, you will pay the difference in cost between the Brand Name Drug and its Generic equivalent.	**100%** up-front cost; paper claim may be submitted to request partial reimbursement	After the second prescription drug fill for Multi-Source Brand Drugs at a retail pharmacy, the Member is responsible for a **$50** co-payment, plus the difference in cost between the Brand Name Drug and its Generic equivalent.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Specialty drugs	**$5** copay/30 day prescription supply at retail. After the second prescription drug fill, the Member is responsible for a **$10** copay; **$10** copay/90 day prescription at mail order. **$20** copay/30 day prescription supply at retail single source brand drug. After the second prescription drug fill, the Member is responsible for a **$40** copay; **$40** copay/90 day prescription at mail order. **$25** copay/30 day prescription supply at retail for multi-source brand drug. After the second prescription drug fill **$50** copay; **$50** copay/90 day prescription at mail order. In addition to the copay amount, you will pay the difference in cost between the Brand Name Drug and its Generic equivalent.	**100%** up-front cost; paper claim may be submitted to request partial reimbursement	Some specialty medications may require Pre-authorization. Additional information regarding the Specialty Pharmacy Service can be obtained by calling 1-800-803-2523 or accessing Express Scripts online at www.express-scripts.com.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**10%** Coinsurance	**40%** Coinsurance	Coverage is limited to **$350**/at a Non-Network Ambulatory Surgery Center.
	Physician/surgeon fees	**10%** Coinsurance	**40%** Coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	**$50** Copay/**10%** Coinsurance	**$50** copay/**10%** Coinsurance	Non-emergency by non-PPO; **$50** copay/**40%** Coinsurance member responsibility. This is for the hospital/facility charge only. The ER physician charge may be separate.
	Emergency medical transportation	**20%** Coinsurance	**20%** coinsurance	If Medically Necessary for the Member to be moved via ambulance from one facility to another, services are covered at **100%.**
	Urgent care	**$15** Copay	**40%** Coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	**10%** Coinsurance	Non-emergency and non- PPO; **$540.00** Inpatient Daily Maximum scheduled amount. The plans' payment shall not exceed **90%** of the scheduled amount listed above.	Utilization review is required for inpatient hospital admissions with the exception of maternity care of 48 hours or less for normal delivery or 96 hours or less following a cesarean section and limply node dissection. To initiate pre-service review contact Anthem Blue Cross at 1-800-274-7767 at least three working days prior to when the Member is scheduled to receive services. Services not preauthorized may not be covered.
	Physician/surgeon fee	**10%** Coinsurance	**40%** Coinsurance	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**10%** Coinsurance	**40%** Coinsurance	For additional information please refer to the CAHP Health Benefits Trust Evidence of Coverage Booklet under section; Covered Medical Services and Supplies.
	Mental/Behavioral health inpatient services	**10%** Coinsurance	Non-emergency and non-PPO; **$540.00** Inpatient Daily Maximum scheduled amount. The plans' payment shall not exceed **90%** of the scheduled amount listed above.	Utilization review is required for inpatient hospital admissions with the exception of maternity care of 48 hours or less for normal delivery or 96 hours or less following a cesarean section and lymph node dissection. To initiate pre-service review contact Anthem Blue Cross at 1-800-274-7767 at least three working days prior to when the Member is scheduled to receive services. Services not preauthorized may not be covered.
	Substance use disorder outpatient services	**10%** Coinsurance	**40%** Coinsurance	For additional information please refer to the CAHP Health Benefits Trust Evidence of Coverage Booklet under section; Cover Medical Services and Supplies.
	Substance use disorder inpatient services	**10%** Coinsurance	Non-emergency and non- PPO; **$540.00** Inpatient Daily Maximum scheduled amount. The plans' payment shall not exceed **90%** of the scheduled amount listed above.	Utilization review is required for inpatient hospital admissions with the exception of maternity care of 48 hours or less for normal delivery or 96 hours or less following a cesarean section and lymph node dissection. To initiate pre-service review contact Anthem Blue Cross at 1-800-274-7767 at least three working days prior to when the Member is scheduled to receive services. Services not preauthorized may not be covered.
If you are pregnant	Prenatal and postnatal care	**10%** Coinsurance	**40%** Coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	**10%** Coinsurance	Non-emergency & non- PPO; **$540** Inpatient Daily Maximum scheduled amount. The plans' payment shall not exceed **90%** of the scheduled amount listed above.	Utilization review is required for inpatient hospital admissions with the exception of maternity care of 48 hours or less for normal delivery or 96 hours or less following a cesarean section and limply node dissection. To initiate pre-service review contact Anthem Blue Cross at 1-800-274-7767 at least three working days prior to when the Member is scheduled to receive services. Services not preauthorized may not be covered.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**10%** Coinsurance	**40%** Coinsurance	90 visits maximum for each period of disability. Prior authorization is required. Services not preauthorized may not be covered.
	Rehabilitation services	**10%** Coinsurance	**40%** Coinsurance	Prior authorization is required for all physical and occupational therapy benefits in excess of 24 visits in a Year. Services not preauthorized may not be covered.
	Habilitation services	**10%** Coinsurance	**40%** Coinsurance	Prior authorization is required.
	Skilled nursing care	**10%** Coinsurance	**40%** Coinsurance	100 days maximum per confinement period. Prior authorization is required. Services not preauthorized may not be covered.
	Durable medical equipment	**10%** Coinsurance	**40%** Coinsurance	Prior authorization can be obtained if the durable medical equipment purchase price is **$5,000** or more.
	Hospice service	No Charge	No Charge	The Member must be suffering from a terminal illness for which the prognosis of life expectancy is six months or less, as certified to Anthem Blue Cross by the physician.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	--------none--------
	Glasses	Not Covered	Not Covered	--------none--------
	Dental check-up	Not Covered	Not Covered	--------none--------

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 services
- Dental Implants
- Infertility treatment
- Long-term care
- Personal development programs
- Private-duty nursing
- Routine foot care (unless you have been diagnosed with diabetes. Consult your formal contract of coverage
- Vision Services or Supplies

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.)

- Bariatric surgery (For morbid obesity. Consult your formal contract of coverage)
- Hearing Aids (Up to **$1,000** every 36 months)
- 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, maybe 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 (in writing within 60 days of notice of denial) P.O. Box 60007 Los Angeles, CA 90060-0007 Attn: CAHP Unit
If Anthem Blue Cross affirms the denial the following steps apply:
STEP 2: Special Review Procedures for Denial of Experimental of Investigational Treatment STEP 3: Independent External Review
STEP 4: Administrative Appeal Process STEP 5: Binding Arbitration (or Small Claims Court)

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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 adoolwol íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į 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 mãi 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.

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** $6,650
- **Patient pays** $895

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	$730
Limits or exclusions	$150
Total	**$895**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,830
- **Patient pays** $570

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	$140
Limits or exclusions	$80
Total	**$570**

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.

What does a Coverage Example show?

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

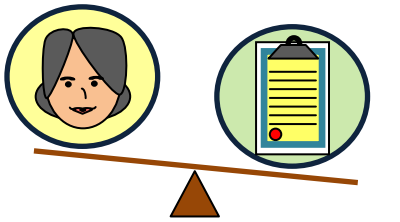
A request for your health insurer or plan to review a decision or a grievance again.

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.



Jane pays 20% | Her plan pays 80%

(See page 4 for a detailed example.)

Complications of Pregnancy

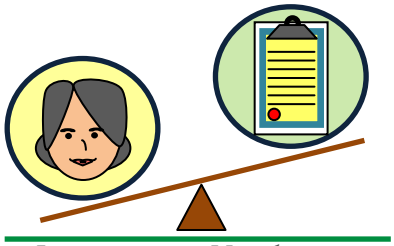
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

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.



Jane pays 100% | Her plan pays 0%

(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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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.

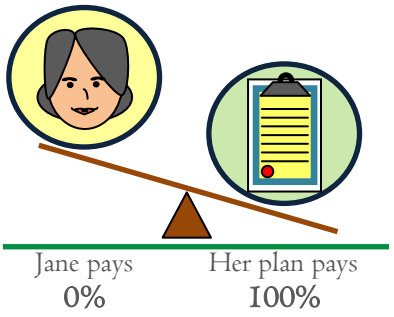
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

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


(See page 4 for a detailed example.)

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.

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.

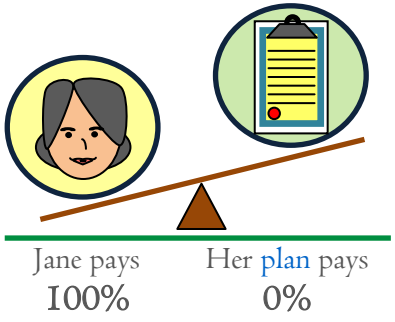
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

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

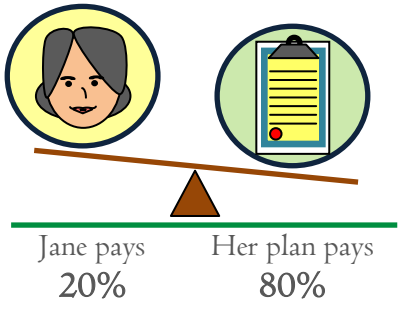


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

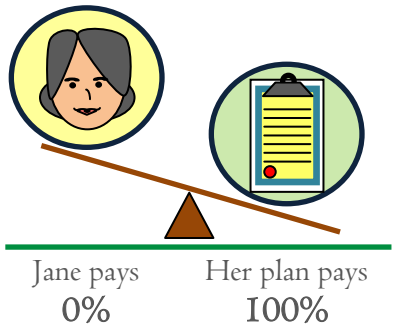


Jane reaches her $1,500 deductible, co-insurance begins

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