

Anthem Blue Cross CalPERS PERSCare 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/calpers or by calling 1-877-737-7776.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>For PPO Providers: \$500 Member/\$1,000 Family For Non-PPO Providers: \$500 Member/\$1,000 Family Does not apply to Preventive Care Services, Office Visits and Prescription Drugs. PPO Provider and Non-PPO Provider deductibles are combined.</p>	<p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered service you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u>.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes. \$250/Admission for Non-Anthem Blue Cross PPO hospital or residential treatment center (waived for emergency admission). \$50/Visit for Emergency Room services (waived if admitted directly from ER).</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes. For PPO Providers: \$5,150 Single/\$10,300 Family For Non-PPO Providers: No Out-Of-Pocket limit when using a Non-PPO Provider. <u>For Pharmacy/Prescription Expenses:</u> \$2,000 Single/\$4,000 Family Mail Order:\$1,000</p>	<p>The <u>out-of-pocket limit</u> 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.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, balance-billed charges, Non-PPO Provider services, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u></p>
<p>Does this plan use a <u>network of providers</u>?</p>	<p>Yes. See www.anthem.com/ca/calpers for a list of PPO Providers or call 1-877-737-7776.</p>	<p>If you use an in-network doctor of other health care <u>provider</u>, this plan will pay some or all of the costs of covered services. Be aware, our in-network doctor of hospital may use an out-of-network <u>provider</u> for some services. Plan 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>.</p>

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/sbcuniformglossary.pdf or call 1-877-737-7776 to request a copy.

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Do I need a referral to see a <u>specialist</u> ?	No.	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 a PPO Provider	Your Cost If You Use a Non-PPO 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	\$20 Copay/visit	40% Coinsurance of allowed amount	-----none-----
	Specialist visit	\$20 Copay/visit	40% coinsurance of allowed amount	-----none-----
	Other practitioner office visit	Acupuncture & Chiropractic \$15 Copay/visit	40% coinsurance of allowed amount	Acupuncture and Chiropractic benefits are limited to a combined maximum of 20 visits per calendar year.
	Preventive care/screening /immunization	No Cost Share	40% Coinsurance of allowed amount	-----none-----

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If you have a test	Diagnostic test (x-ray, blood work)	<u>Lab & X-Ray-Office</u> 10% Coinsurance	<u>Lab & X-Ray-Office</u> 10% Coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	40% Coinsurance of allowed amount	Pre-authorization required.
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	\$5/34 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	\$20/34 day supply \$40/90 day supply	Not Covered 100% Out of Pocket	
	Non-preferred brand drugs	\$50/34 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.
If you have outpatient surgery	Facility fee e.g. Ambulatory Surgery Center; ASC	10% Coinsurance	40% Coinsurance of allowed amount	Services and supplies for the following outpatient surgeries are limited: Colonoscopy limited to \$1,500 per procedure, Cataract surgery limited to \$2,000 per procedure; Arthroscopy limited to \$6,000 per procedure. Benefits limited to \$350 for ASC per day for Non-PPO providers.
	Physician/surgeon fees	10% Coinsurance	40% Coinsurance of allowed amount	-----none-----

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If you need immediate medical attention	Emergency room services	10% Coinsurance	10% Coinsurance of allowed amount	Additional deductible of \$50 applies waived if admitted inpatient. This is for the hospital/facility charge only. The ER physician charge may be separate.
	Emergency medical transportation	10% Coinsurance	10% Coinsurance of allowed amount	-----none-----
	Urgent care	\$20 Copay/Visit	40% Coinsurance of allowed amount	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	40% Coinsurance of allowed amount	\$250 Inpatient hospital deductible per admission. Hip and Knee joint replacement surgery will be limited to \$30,000 per procedure. A subset of participating hospitals meets this maximum benefit coverage. Pre-authorization required.
	Physician/surgeon fee	10% Coinsurance	40% Coinsurance of allowed amount	-----none-----

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Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	<u>Office Visit</u> \$20 Copay/Visit <u>Facility Visit-</u> <u>Facility Charges</u> 10% Coinsurance	<u>Office Visit</u> 40% Coinsurance of allowed amount <u>Facility Visit-</u> <u>Facility Charges</u> 40% Coinsurance of allowed amount	-----none-----
	Mental/Behavioral health inpatient services	10% Coinsurance	40% Coinsurance of allowed amount	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> \$20 Copay/Visit <u>Facility Visit-</u> <u>Facility Charges</u> 10% Coinsurance	<u>Office Visit</u> 40% Coinsurance of allowed amount <u>Facility Visit-</u> <u>Facility Charges</u> 40% Coinsurance of allowed amount	-----none-----
	Substance use disorder inpatient services	10% Coinsurance	40% Coinsurance of allowed amount	This is for facility professional services only. Please refer to your hospital stay for facility fee.
If you are pregnant	Prenatal and postnatal care	10% Coinsurance	40% Coinsurance of allowed amount	-----none-----
	Delivery and all inpatient services	10% Coinsurance	40% Coinsurance of allowed amount	\$250 Inpatient hospital deductible per admission.

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If you need help recovering or have other special health needs	Home health care	10% Coinsurance	40% Coinsurance of allowed amount	Up to 100 visits per calendar year. A visit is defined as 4 hours or less of covered services.
	Rehabilitation services	10% Coinsurance	40% Coinsurance of allowed amount	Up to 30 visits per calendar year for outpatient pulmonary rehabilitation. Up to 40 visits per calendar year coverage for outpatient cardiac rehabilitation.
	Habilitation services	10% Coinsurance	40% Coinsurance of allowed amount	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	10% Coinsurance For the first 10 days. 20% Coinsurance For the next 170 days.	40% Coinsurance of allowed amount	Up to 180 days maximum per calendar year. Pre-authorization required.
	Durable medical equipment	10% Coinsurance	40% Coinsurance of allowed amount	-----none-----
	Hospice service	10% Coinsurance	10% Coinsurance of allowed amount	-----none-----
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-----

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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
- Personal development programs
- Private-duty nursing
- Routine eye care (adult)
- Routine foot-care (unless you have been diagnosed with diabetes. Consult your formal contract of coverage)

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, considered an Adverse Benefit Determination (ABD) you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Grievance and Appeals 1-877-737-7776 or Anthem Blue Cross Attention: Grievance and Appeals P.O. Box 60007 Los Angeles, CA 90060-0007
If Anthem Blue Cross upholds the ABD, that decision becomes a Final Adverse Benefit Determination (FABD) and you may request an independent External Review. If you are not satisfied with Anthem Blue Cross' FABD, the independent External Review decision or you do not want to pursue the independent External Review Process, you may request an Administrative Review from CalPERS. The request must be mailed to: CalPERS Health Plan Administration Division/ Health Appeals Coordinator P.O. Box 1953 Sacramento, CA 95812-1953

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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'i, shikáa adoolwol íinízinigo t'áá diné k'éjúgo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ní ba'níja'go ho'aalagíí bich'í hodiilní. Hai'daq íini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bí'ki sí'núilígú bí'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.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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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 \$6,200
- Patient pays \$1,340

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	\$500
Copays	\$20
Coinsurance	\$680
Limits or exclusions	\$150
Total	\$1,340

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

- Amount owed to providers: \$5,400
- Plan pays \$4,310
- Patient pays \$1,090

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	\$500
Copays	\$390
Coinsurance	\$120
Limits or exclusions	\$80
Total	\$1,090

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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?

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.

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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

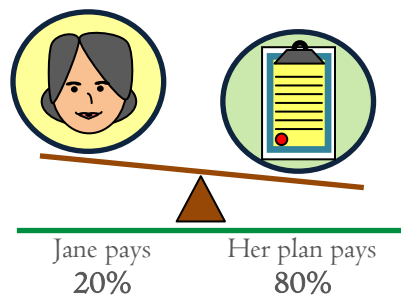
A request for your health insurer or **plan** to review a decision or a **grievance** again.

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

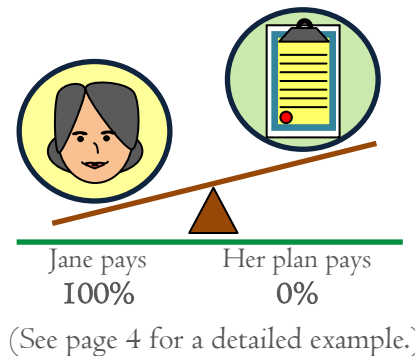
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

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.



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

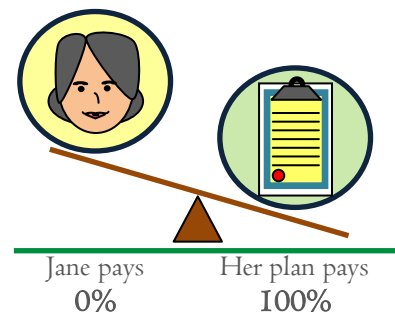
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

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.



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

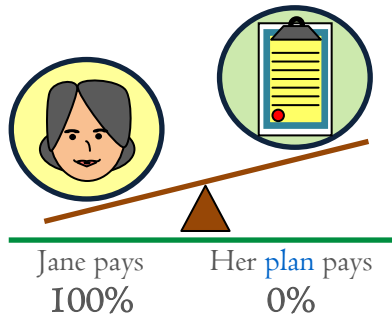
Jane's Plan Deductible: \$1,500

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

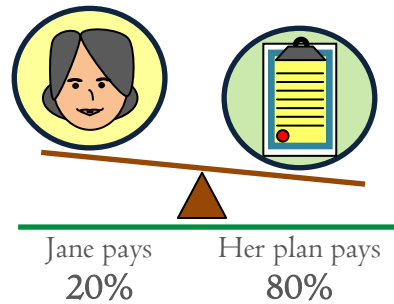
Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0

more costs



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

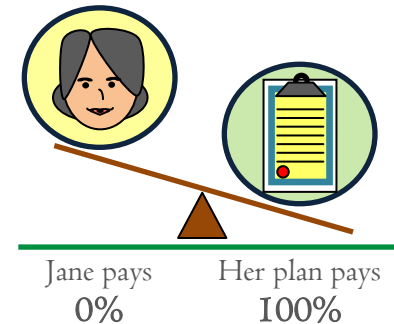
Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.

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