Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Anthem Blue Cross: Traditional HMO Plan for CalPERS

Coverage Period: 01/01/2018 – 12/31/2018
Coverage for: Individual + Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.anthem.com/ca/calpers/hmo. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 839-4524 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$1,500/single or $3,000/family for In-Network Providers. No Out Of Pocket Limit when using Non-HMO Providers. This plan has a separate Out of Pocket Maximum for Prescription Drugs $5,850/individual or $11,700/family, $1,000 Home delivery.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Infertility services, Premiums, Balance-Billing charges, and Health Care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes, California Care HMO. See <a href="http://www.anthem.com/ca/calpers/hmo">www.anthem.com/ca/calpers/hmo</a> or call (855) 839-4524 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$5/30 day supply</td>
<td>Not Covered 100% Out of Pocket</td>
</tr>
<tr>
<td></td>
<td>Brand name formulary drugs</td>
<td>$20/30 day supply</td>
<td>Not Covered 100% Out of Pocket</td>
</tr>
<tr>
<td></td>
<td>Brand name non-formulary drugs</td>
<td>$50/30 day supply</td>
<td>Not Covered 100% Out of Pocket</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Specialty follows the tier structure above</td>
<td>Not Covered 100% Out of Pocket</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee e.g. Ambulatory Surgery Center; ASC</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$50/visit</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15/visit</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at www.anthem.com/ca/calpers/hmo.
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay In-Network Provider (You will pay the least)</th>
<th>What You Will Pay Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit $15/visit Other Outpatient No charge</td>
<td>Office Visit Not covered Other Outpatient Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td><strong>Home health care</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td><strong>Children’s eye exam</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s glasses</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s dental check-up</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover</th>
<th>Check your policy or plan document for more information and a list of any other excluded services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic surgery</td>
<td>• Dental care (adult)</td>
</tr>
<tr>
<td>• Long-term care</td>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Weight loss programs</td>
<td>• Infertility treatment</td>
</tr>
<tr>
<td></td>
<td>• Routine foot care unless you have been diagnosed with diabetes.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at www.anthem.com/ca/calpers/hmo.
**Other Covered Services** (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Acupuncture Rider 20 visits/benefit period combined with Chiropractic care.
- Hearing aids 1 per ear/every 3 years.
- Bariatric surgery (For morbid obesity. Consult your formal contract of coverage)
- Chiropractic care Rider 20 visits/benefit period combined with Acupuncture.
- Routine eye care (adult) one visit/benefit period.
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

---

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at (866) 444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](http://www.healthcare.gov). For more information about the [Marketplace](http://www.healthcare.gov), visit [www.HealthCare.gov](http://www.words.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, 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](http://www.healthhelp.ca.gov)  helpline@dmhc.ca.gov

**Does this plan provide Minimum Essential Coverage?** Yes
If you don’t have [Minimum Essential Coverage](http://www.healthhelp.ca.gov) for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards?** Yes
If your plan doesn’t meet the [Minimum Value Standards](http://www.healthhelp.ca.gov), you may be eligible for a [premium tax credit](http://www.healthhelp.ca.gov) to help you pay for a plan through the [Marketplace](http://www.healthcare.gov).

---

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>■ The plan’s overall deductible</td>
<td>■ The plan’s overall deductible</td>
<td>■ The plan’s overall deductible</td>
</tr>
<tr>
<td>■ Specialist copayment</td>
<td>■ Specialist copayment</td>
<td>■ Specialist copayment</td>
</tr>
<tr>
<td>■ Hospital (facility) coinsurance</td>
<td>■ Hospital (facility) coinsurance</td>
<td>■ Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>■ Other coinsurance</td>
<td>■ Other coinsurance</td>
<td>■ Other coinsurance</td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>$15</td>
<td>$15</td>
<td>$15</td>
</tr>
<tr>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost: $12,840

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$70</td>
<td>$3,670</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions $60
- The total Peg would pay is $130

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

Total Example Cost: $7,460

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$3,691</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions $21
- The total Joe would pay is $3,691

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost: $2,010

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$255</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions $0
- The total Mia would pay is $255

The plan would be responsible for the other costs of these EXAMPLE covered services.
Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 839-4524

Arabic: إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 839-4524 (الربية).

Armenian (hyeṙen). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկություններ։ Թարգմանչի հետ խոսելու համար զանգահարեք (855) 839-4524:

Bassa (Bàssà Wùɖ̀): M dyi dyi-die-dè bë bécéh bá céé-de nià ke dyí ní, c mò ni dyi-bëdëɛɛn-dë bë m ké gbo-krá-krá ké bô kpö dé m bìdi-wùdùùn bó pìdyi. Bë m ké wùdù-zìín-nyò dò gbo wùdù ke, qà (855) 839-4524.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও ভাষায় পাওয়ার অধিকার আপনার আছে। একজন ভাষার্থীর সাথে কথা পরার জন্য (855) 839-4524 -তে কল করুন।

Burmese (မြန်မာ): သင် ဖိဝါးသို့မဟုတ် ဖိန်စာရင်း တွင် ပါဝင်သော အချက်အလက်များစာရင်းအတွက် ဖိဝါးအကြောင်း အနည်းငယ်ချိန် ရှိနေသော အချက်အလက်များထဲမှ အခြေခံ အသုံးများထားသော အချက်အလက်များကို မှတ်ပုံတမ်းတင်ပြီး (855) 839-4524 ကြည့်ပါ။

Chinese (中文)：如果您对本文件有任何疑问，您有权利使用您的语言免费获得协助和资讯。如需与译员通话，请致电 (855) 839-4524。

Dinka (Dinka): Na nọŋ thëëtë nē ke de yā thòrë, ke yin nọŋ loŋ bë yi kuony ku wer akë bë geë rëc yin ne thon du ke cin wëu tàstë ke pîny. Te kôr yin ba jëm wënhè ran ye thok gëtyic, ke yin cól (855) 839-4524.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 839-4524.

Farsi (فارسی): در صورتی که سوالی پیرامون این سند داردید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادریتتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 839-4524 (855) تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète,appelez le (855) 839-4524.
Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 839-4524.

**Greek (Ελληνικά):** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 839-4524.

**Gujarati (સુઝગ્રહી):** જો આ રસ્તાપદેશ અંગે આપણે સ્કોપિયલ પ્રશ્નો હોય તો, સ્કોપિયલ પાર આપની ભાષામાં મહત અને મહત્ત્વના વિષય તમને અધિકાર છે. તેથી અમે તમારી વાત સાથે વાત કરીશ માટે, પણ કોઈ ભાષા (855) 839-4524.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 839-4524.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको नि:शुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। तुम्हारी सहायता के लिए, कॉल करें (855) 839-4524.

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 839-4524.

**Igbo (Igbo):** Ọ bụrụ na ị nwere adhị ọ bụla gbasara akwụkwọ a, ị nwere ike ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgbọ ọ bụla. Ka gị na ọkọwa okwu kwuoku, kpọọ (855) 839-4524.

**Ilokano (Ilokano):** Nu addaan ka iti aniama a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 839-4524.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 839-4524.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 839-4524.

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 839-4524 にお電話ください。
Language Access Services:

Khmer (ខ្មែរ): បើការសិទ្ធិក្នុងប្រយោជន៍នេះក៏សម្រាប់អ្នក ប្រើប្រាស់ព័ត៌មានដែលគ្រប់គ្រងនូវប្រយោគសេសគ្មេមមការដោយ (855) 839-4524 ។

Kirundi (Kirundi): Ugieze ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 839-4524.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 839-4524 로 문의하십시오.

Lao (ລາວ): ເນາavo ການຈັດຕັ້ງບີລາວໂປຣການ, ການນຳເຂົ້າສີ່ຄາວໂຕບັດເລີ່ມຢ່າງເຊິ່ງ ເຊິ່ງ ເອນຕະການມາຍະລັງຄະນາການຄວາມດັ່ງ. ແຕ່ເວລານຳຄ່າແຕ່ປະມານ, ໃຫ້ທ້າທາ (855) 839-4524.

Navajo (Dine): Díi naalthsoos biká’igií lahdgo bina’idilkidgo ná bohónéedzą dóó bee ahóót’ii’ táá ni nizada k’ehjí bee niil hodonih t’áadoo bááh ilinígóó. Aťe halné’igii la’ bich’i’ hadeesdzíh níningingo kojí hodiilnih (855) 839-4524.

Nepali (नेपाली): यदि यो कामनातै तपाईले गरी यो प्रश्न छूनौ भने, तपाईंले भाषामा निश्चित सहयोग तथा जानकारी प्राप्त गर्न पाने हुन तपाईंले गरी (855) 839-4524.

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaq qabdaa. Turjumaana dubaachuuf, (855) 839-4524 bilbilla.


Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 839-4524.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (855) 839-4524.

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interprét, contactați teleonic (855) 839-4524.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 839-4524.

Samoan (Samoa): Afai e iai ni ou fesi e uiiga i leni tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (855) 839-4524.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (855) 839-4524.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 839-4524.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 839-4524.

Thai (ไทย): หากคุณมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (855) 839-4524 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): Якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зв'яжіться з нами по номеру (855) 839-4524.

Urdu (اردو): اگر اس دستاپ کے بارے میں کوئی سوال ہے، تو آپ کو مدد اور اپنے زبان میں مفت معلومات حاصل کرنا ہے کہ حق حاصل ہے، کیا متوجھ سے بات کرنا ہے؟ (855) 839-4524

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 839-4524.

Yiddish (אידיש): ייידיש קליינט עס טעט קRowCountן דעם דקאורמונט, האן אייר די ר┽נ kino דעם דקאורמונט יא废弃 איטליאני פראבאאך אארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קארא קאราช

Yoruba (yorùbá): Tí o bá ní èyíkéyì ìbèèrì nípa àkọsìlé yìí, o ní ètò láti gba iránwò àti iwiìní ní èdè re lọfèè. Bá wa ogbùrù kan sòrò, pe (855) 839-4524.
Language Access Services:

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Glossary of Health Coverage and Medical Terms

- This glossary defines 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 or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any 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.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

**Allowed Amount**
This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

**Appeal**
A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

**Balance Billing**
When a provider bills you for the balance remaining on the bill that your plan doesn’t cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider’s charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

**Claim**
A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

**Coinsurance**
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance 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 coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

**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 generally aren’t complications of pregnancy.

**Copayment**
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.

**Cost Sharing**
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn’t cover usually aren’t considered cost sharing.

**Cost-sharing Reductions**
Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you’re a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.
Deductible
An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (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.)

Jane pays 100% of her deductible. Her plan pays 0% of the deductible. (See page 6 for a detailed example.)

Diagnostic Test
Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition
An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn’t get medical attention right away. If you didn’t get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation
Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services
Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital’s emergency room or other place that provides care for emergency medical conditions.

Excluded Services
Health care services that your plan doesn’t pay for or cover.

Formulary
A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

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 a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a “policy” or “plan”.

Home Health Care
Health care services and supplies you get in your home under your doctor’s orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn’t include help with non-medical tasks, such as cooking, cleaning, or driving.

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. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn’t require an overnight stay.
Individual Responsibility Requirement
Sometimes called the “individual mandate”, the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don’t have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
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 copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an “Exchange”. The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

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

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you’re offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

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

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don’t contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
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 copayments usually are more than in-network copayments.
Out-of-network Provider (Non-Preferred Provider)
A provider who doesn’t have a contract with your plan to provide services. If your plan covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider”.

Out-of-pocket Limit
The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn’t cover. Some plans don’t count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan
Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called “health insurance plan”, "policy", "health insurance policy" or "health insurance".

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) 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.
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.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don’t get a referral first, the plan may not pay for the services.

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.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as “skilled care services”, which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

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  
Coinurance: 20%  
Out-of-Pocket Limit: $5,000

<table>
<thead>
<tr>
<th>January 1st</th>
<th>December 31st</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning of Coverage Period</td>
<td>End of Coverage Period</td>
</tr>
</tbody>
</table>

Jane pays 100%  
Her plan pays 0%

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

Jane reaches her $1,500 deductible, coinurance begins

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

Office visit costs: $125  
Jane pays: 20% of $125 = $25  
Her plan pays: 80% of $125 = $100

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: $125  
Jane pays: $0  
Her plan pays: $125