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 see [www.kp.org/plandocuments](http://www.kp.org/plandocuments) or call 1-800-278-3296 (TTY: 711). 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 [http://www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-278-3296 (TTY: 711) to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>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>Not Applicable.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</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>Medical: $1,500 Individual / $3,000 Family Drugs: $5,850 Individual / $11,700 Family</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>Premiums, and health care services this plan doesn’t cover, indicated in chart starting on page 2.</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. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-278-3296 (TTY: 711) 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, but you may self-refer to certain specialists.</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>Plan Provider (You will pay the least)</th>
<th>Non-Plan Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness $15 / visit</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit $15 / visit</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization No charge</td>
<td>Not covered</td>
<td>You may have to pay for services that aren’t <strong>preventive</strong>. Ask your <strong>provider</strong> if the services needed are <strong>preventive</strong>. Then check what your <strong>plan</strong> will pay for.</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work) No charge</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs) No charge</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs Plan pharmacy: $5 retail; $10 mail order / prescription</td>
<td>Not covered</td>
<td>Up to 30-day supply retail and 100-day supply mail order. Subject to formulary guidelines.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs Plan pharmacy: $20 retail; $40 mail order / prescription</td>
<td>Not covered</td>
<td>Up to 30-day supply retail and 100-day supply mail order. Subject to formulary guidelines.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs Same as preferred brand drugs</td>
<td>Not covered</td>
<td>Same as preferred brand drugs when approved through exception process.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs Same as preferred brand drugs</td>
<td>Not covered</td>
<td>Same as preferred brand drugs when approved through exception process.</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center) $15 / procedure</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees Included in Facility Fee</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical</td>
<td>Emergency room care $50 / visit</td>
<td>$50 / visit</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
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<tr>
<td>attention</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical</td>
<td>No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15 / visit</td>
<td></td>
<td></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>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon</td>
<td>No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Mental / Behavioral health: $15 / individual visit; No charge for other outpatient services; Substance Abuse: $15 / individual visit; $5 / visit for other outpatient services</td>
<td>Not covered</td>
<td>Mental / Behavioral health: $7 / group visit Substance Abuse: $5 / group visit</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
<td>Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
<td>Up to 2 hour limit / visit, up to 3 visit limit / day, up to 100 visit limit / year</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Inpatient: No charge; Outpatient: $15 / visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Plan Provider (You will pay the least)</td>
<td>Non-Plan Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>--------------------</td>
<td>----------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Inpatient: No charge; Outpatient: $15 / visit</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
<td>100 day limit / benefit period.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
<td>Subject to formulary guidelines.</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

| Children’s eye exam | No charge for refractive exam | Not covered | None |
| Children’s glasses | Not covered | Not covered | None |
| Children’s dental check-up | Not covered | Not covered | None |

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover** (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Children’s glasses
- Dental care (Adult and child)
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs

**Other Covered Services** (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (20 visits limit/year combined with chiropractic)
- Bariatric surgery
- Chiropractic care (20 visits limit/year combined with acupuncture)
- Hearing aids ($1,000 limit / ear every 36 months)
- Infertility treatment
- Routine eye care (Adult)
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 shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.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 the agencies in the chart below. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care and Department of Insurance at 980 9th St, Suite #500 Sacramento, CA 95814, 1-888-466-2219 or http://www.HealthHelp.ca.gov.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Contact Information</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente Member Services</td>
<td>1-800-278-3296 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a></td>
<td></td>
</tr>
<tr>
<td>Department of Labor’s Employee Benefits Security Administration</td>
<td>1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a></td>
<td></td>
</tr>
<tr>
<td>Department of Health &amp; Human Services, Center for Consumer Information &amp; Insurance Oversight</td>
<td>1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a></td>
<td></td>
</tr>
<tr>
<td>California Department of Insurance</td>
<td>1-800-927-HELP (4357) or <a href="http://www.insurance.ca.gov">www.insurance.ca.gov</a></td>
<td></td>
</tr>
<tr>
<td>California Department of Managed Healthcare</td>
<td>1-888-466-2219 or <a href="http://www.healthhelp.ca.gov">www.healthhelp.ca.gov</a></td>
<td></td>
</tr>
</tbody>
</table>

Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage 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, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 (TTY: 711)
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-757-7585 (TTY: 711)
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijjigo holne’ 1-800-278-3296 (TTY: 711)

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 (9 months of in network prenatal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in network care of a well controlled condition)</th>
<th>Mia’s Simple Fracture (in network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td>$15</td>
<td>$15</td>
</tr>
<tr>
<td><strong>Hospital (facility) copayment</strong></td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Other (blood work) copayment</strong></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** $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $60
- **The total Peg would pay is** $260

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** $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$600</td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $50
- **The total Joe would pay is** $650

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** $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $0
- **The total Mia would pay is** $100

The plan would be responsible for the other costs of these EXAMPLE covered services.
Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call 1-800-464-4000 (TTY users call 711).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. A grievance includes a complaint or an appeal. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your Evidence of Coverage or Certificate of Insurance, or speak with a Member Services representative for the disputeresolution options that apply to you. This is especially important if you are a Medicare, MediCal, MRMIP, MediCal Access, FEHBP, or CalPERS member because you have different disputeresolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to Your Guidebook for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to Your Guidebook for addresses)
- By calling our Member Service Contact Center toll free at 1-800-464-4000 (TTY users call 711)
- By completing the grievance form on our website at kp.org

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

**Language Assistance Services**

**English:** We provide interpreter services at no cost to you, 24 hours a day, 7 days a week, during all hours of operation. You can have an interpreter help answer your questions about our health care coverage. You can also request materials translated in your language at no cost to you, 24 hours a day, 7 days a week (closed holidays). TTY users call 711.

**Arabic:** نقوم بتقديم خدمات الترجمة باللغة العربية بتكاليف مجانًا. يمكنكم الاتصال بنا في أي وقت من اليوم، 7 أيام في الأسبوع، خلال كل فترات العمل. بالإضافة إلى ذلك، يمكنكم طلب ترجمة الوثائق الطبية للعملاء مجانًا. ما عليك سوى الاتصال بنا على الرقم 1-800-464-4000 (1-800-464-4000) على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمات الهاتف النصي برجي الاتصال على الرقم (711).

**Armenian:** Մենք օր 24 ժամ, շաբաթը 7 օր, մինչև չգործող րոպե փորձում են համար տված ժամանակաշրջանում խաղաղ սահմանափակում տալ պատասխանները: Մշտապես պատասխանին ինչևս կարելի է հանդիսանալ՝ եթե սահմանափակումը չկարելու վերաքշաման վերացումից սկսվում է դրանք. Թվային երկնք կարելի է փորձել սահմանափակումների փոփոխություններին, որոնք 24 ժամ չափազանց են ենթադրվել: Պարզապես զանգահարեք մեզ, որ բանավոր թարգմանչի ծառայություններ 1-800-464-4000 թվով ինչպես անվճար են: Պատասխան ստանալ Ձեր հարցերին` մեր կողմից տրամադրվող ժամերին Ձեզ համար անվճար բանավոր թարգմանչի ծառայություններ (միտապես այս թարգմանչի ծառայությունները): (711)

**Hindi:** हम संग्रहण के सभी घंटों के दौरान आपको बिना किसी लागत के मुक्ति प्रदान करते हैं, जिन के 24 घंटे, सप्ताह के सात दिन प्रदान करते हैं. आप हमारी स्वास्थ्य देखभाल करें, जो बेहतर और सुसंगत होगा, क्योंकि हम अपनी किस्मत प्रदान करते हैं. हम आपकी मदद के सामग्री को अनुसार मांगते हैं और आपको बिना किसी लागत के सामग्री को उपलब्ध कराते हैं. हम न हैं 1-800-464-4000 पर, विक्रेता दिन 24 घंटे, सप्ताह के सात दिन (छुट्टियों बाद दिन बंद रहता है) कॉल करें. TTY उपयोगकर्ता 711 पर कॉल करें.
Navajo: Nihí ata’ halne’é aḵá’adoowoligí nihei hóló t’áá jiį́ʼé, t’áá naadiin diį́ʼ aheéʼilkeego, tsosts’id yiskáajíʼí, ndá’anišhgo oolkíl biyi’í góó. Ata’ halne’é niká’adoowol na’idikid nee hólóóo diį́ʼ ats’ís baa áháyáá bik’estí iigí bíná’díldíldigo. Áídóó aldo’ naaltsos lo t’aá ní níizaad k’e’éhjí ahnéehgo t’áá jiį́ʼí ádooníí. Nííichí’íi’i hodiíniíní koijí 1-800-464-4000 jiįgo dóó t’íi’é níí, tsosts’id yiskáajíʼí dimoo na’adleejíʼí (Holidaysgo éi da’deelkaal) doo da’díits’a’i igní chodayool’íigní koijí’i hodiíniíní 711.

Punjabi: ਅਕਸ਼ ਲਾਫ਼ ਦੀ ਦੇ ਮੰਚ ਪੀਠਾਘ ਦੇ ਕਾਂਠ, ਦੁਰਿਆਂ ਵਿਚ ਬਿਨੀ ਲੱਗਾਨਾ ਦੇ, ਦੀਰੀਦੇ 24 ਫੋਨਾ, ਜਹਾਂ ਦੇ 7 ਦਿਨਾਂ, ਲੱਗਾਣਾ ਵੇਲਾਨੂੰ ਮੂਟੀਆਂ ਵਲਾਦੀੱਤ ਹੋਣਾ ਦੇ। ਅਕਸ਼ ਲਾਫ਼ ਵਿਚ ਦੁਰਿਆਂ ਵਲਾਦੀੱਤ ਹੋਣਾ ਦੇ ਮੰਚ ਦੀ ਦੀਰੀਦੇ ਦੀ ਭੇਡਾ ਮੰਚ ਦੇ ਦੀਰੀਦੇ ਦੇ। ਅਕਸ਼ ਵੀ ਦੀਰੀਦੇ ਦੀ ਲੱਗਾਣਾ ਦੇ ਮੂਟੀਆਂ ਦੀ ਦੀਰੀਦੇ ਦੇ ਉਦੀੱਤ ਦੇ ਦੀਰੀਦੇ ਦੇ। ਘਾਮ ਮੰਚ ਦੀ ਸੂਚਿ 1-800-464-4000 ਦੇ, ਦੀਰੀਦੇ 24 ਫੋਨਾ, ਜਹਾਂ ਦੇ 7 ਦਿਨਾਂ (ਭੂਤੀਆਂ ਦੀ ਦੀਰੀਦੇ ਦੀ ਦੁਸ਼ਮਨੀ ਦੇ) ਦੋਹਾ ਦੇ। TTY ਦੁੱਪੋਰਤ ਵਲਾਦੀੱਤ ਦੇ ਦੀਰੀਦੇ 711 ‘ਤੇ ਦੋਹਾ ਦੇ।

Russian: Мы всегда в часы работы обеспечиваем Вас услугами устного переводчика, 24 часа в сутки, 7 дней в неделю. Чтобы получить ответы на свои вопросы о нашем страховом покрытии услуг здравоохранения, Вы можете воспользоваться помощью устного переводчика. Вы также можете запросить бесплатный перевод материалов на Ваш язык. Просто позвоните нам по телефону 1-800-464-4000, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру 711.

Spanish: Ofrecemos servicios de traducción al español sin costo alguno para usted durante todo el horario de atención, 24 horas al día, siete días a la semana. Puede contar con la ayuda de un intérprete para responder las preguntas que tenga sobre nuestra cobertura de atención médica. Además, puede solicitar que los materiales se traduzcan a su idioma sin costo alguno. Solo llame al 1-800-788-0616, 24 horas al día, siete días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al 711.

Tagalog: May magagamit na mga serbisyo ng tagasalin ng wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo, sa lahat oras ng trabaho. Makakatulong ang tagasalin ng wika sa pagsasot sa mga tanong mo tungkol sa iyong coverage sa pangangalagang pangkalusugan. Maaari kang humingi ng mga babasahin na isinalin sa iyong wika nang wala kang babayaran. Tawagan lamang kami sa 1-800-464-4000, 24 na oras bawat araw, 7 araw bawat linggo (sarádo sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa 711.

Thai: เรามีบริการตามที่สำรองคุณสมบัติ 24 ชั่วโมงทุกวัน ทุกวันทำการของเราสามารถให้บริการตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแลสุขภาพของเราระดับฉุกเฉินสามารถขอให้การแปลเอกสารเป็นภาษาที่คุณใช้โดยไม่มีการคิดค่าบริการเพียงโทรมาที่หมายเลข 1-800-464-4000 ตลอด 24 ชั่วโมงทุกวัน (โปรดให้บริการในวันหยุดราชการ) คุณใช้TTY โปรดโทรไปที่ 711.

Chinese: 我們每週 7 天，每天 24 小時在所有營業時間內免費為您提供口譯服務。您可以請口譯員協助回答有關我們健康保險的問題。您也可以免費索取翻譯成您所用語言的資料。我們每逢 7 天，每天 24 小時歡迎您打電話 1-800-757-7585 前來聯絡（假日除外）。聽障及語障專線 (TTY) 使用者請撥 711。

Vietnamese: Chúng tôi cung cấp dịch vụ thông dịch miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần, trong tất cả các giờ làm việc. Quý vị có thể được hỗ trợ dịch vụ trả lời thắc mắc về quyền lợi bảo hiểm sức khỏe của chúng tôi. Quý vị cũng có thể yêu cầu được cấp miễn phí tài liệu phiên dịch ra ngôn ngữ của quý vị. Ở đây có cho chúng tôi tại số 1-800-464-4000, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi 711.
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 and her plan pays 0%.

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.

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.
**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.

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.

Premium Tax Credits
Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage
Coverage under a plan that helps pay for prescription drugs. If the plan’s formulary uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you’ll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs
Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider
An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be 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.

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  
Coinsurance: 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

Jane reaches her $1,500 deductible, coinsurance 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

Glossary of Health Coverage and Medical Terms