



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> or call 1-800-278-3296 (TTY: 711) to request a copy.

| Important Questions                                                             | Answers                                                                                                                                 | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0                                                                                                                                     | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Not Applicable.                                                                                                                         | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                      |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                     | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Medical: \$1,500 Individual / \$3,000 Family<br>Drugs: \$5,850 Individual / \$11,700 Family                                             | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                            |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , and health care services this <a href="#">plan</a> doesn't cover, indicated in chart starting on page 2.     | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-278-3296 (TTY: 711) for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's charge</a> and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes, but you may self-refer to certain <a href="#">specialists</a> .                                                                    | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                     |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                                                                                                                                                                | Services You May Need                                  | What You Will Pay                                                          |                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                     |                                                        | Plan Provider<br>(You will pay the least)                                  | Non-Plan Provider<br>(You will pay the most) |                                                                                                                                                                                                                             |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>                                                                                                                                       | Primary care visit to treat an injury or illness       | \$15 / visit                                                               | Not covered                                  | None                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                     | <a href="#">Specialist</a> visit                       | \$15 / visit                                                               | Not covered                                  | None                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                     | <a href="#">Preventive care/screening/immunization</a> | No charge                                                                  | Not covered                                  | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. |
| <b>If you have a test</b>                                                                                                                                                                                           | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge                                                                  | Not covered                                  | None                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                     | Imaging (CT/PET scans, MRIs)                           | No charge                                                                  | Not covered                                  | None                                                                                                                                                                                                                        |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a> | Generic drugs                                          | Plan pharmacy: \$5 retail; \$10 mail order / <a href="#">prescription</a>  | Not covered                                  | Up to 30-day supply retail and 100-day supply mail order. Subject to <a href="#">formulary</a> guidelines.                                                                                                                  |
|                                                                                                                                                                                                                     | Preferred brand drugs                                  | Plan pharmacy: \$20 retail; \$40 mail order / <a href="#">prescription</a> | Not covered                                  | Up to 30-day supply retail and 100-day supply mail order. Subject to <a href="#">formulary</a> guidelines.                                                                                                                  |
|                                                                                                                                                                                                                     | Non-preferred brand drugs                              | Same as preferred brand drugs                                              | Not covered                                  | Same as preferred brand drugs when approved through exception process.                                                                                                                                                      |
|                                                                                                                                                                                                                     | <a href="#">Specialty drugs</a>                        | Same as preferred brand drugs                                              | Not covered                                  | Same as preferred brand drugs when approved through exception process.                                                                                                                                                      |
| <b>If you have outpatient surgery</b>                                                                                                                                                                               | Facility fee (e.g., ambulatory surgery center)         | \$15 / procedure                                                           | Not covered                                  | None                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                     | Physician/surgeon fees                                 | Included in Facility Fee                                                   | Not covered                                  | None                                                                                                                                                                                                                        |
| <b>If you need immediate medical</b>                                                                                                                                                                                | <a href="#">Emergency room care</a>                    | \$50/ visit                                                                | \$50 / visit                                 | None                                                                                                                                                                                                                        |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                                                                                  |                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                  |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Plan Provider<br>(You will pay the least)                                                                                                                                                          | Non-Plan Provider<br>(You will pay the most) |                                                                                                                                                                                                                                         |
| attention                                                                 | <a href="#">Emergency medical transportation</a> | No charge                                                                                                                                                                                          | No charge                                    | None                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Urgent care</a>                      | \$15 / visit                                                                                                                                                                                       | \$15 / visit                                 | <a href="#">Non-Plan providers</a> covered when temporarily outside the service area.                                                                                                                                                   |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | No charge                                                                                                                                                                                          | Not covered                                  | None                                                                                                                                                                                                                                    |
|                                                                           | Physician/surgeon fees                           | No charge                                                                                                                                                                                          | Not covered                                  | None                                                                                                                                                                                                                                    |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | <b>Mental / Behavioral health:</b> \$15 / individual visit; No charge for other outpatient services;<br><b>Substance Abuse:</b> \$15 / individual visit; \$5 / visit for other outpatient services | Not covered                                  | <b>Mental / Behavioral health:</b> \$7 / group visit<br><b>Substance Abuse:</b> \$5 / group visit                                                                                                                                       |
|                                                                           | Inpatient services                               | No charge                                                                                                                                                                                          | Not covered                                  | None                                                                                                                                                                                                                                    |
| If you are pregnant                                                       | Office visits                                    | No charge                                                                                                                                                                                          | Not covered                                  | Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
|                                                                           | Childbirth/delivery professional services        | No charge                                                                                                                                                                                          | Not covered                                  | None                                                                                                                                                                                                                                    |
|                                                                           | Childbirth/delivery facility services            | No charge                                                                                                                                                                                          | Not covered                                  | None                                                                                                                                                                                                                                    |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | No charge                                                                                                                                                                                          | Not covered                                  | Up to 2 hour limit / visit, up to 3 visit limit / day, up to 100 visit limit / year                                                                                                                                                     |
|                                                                           | <a href="#">Rehabilitation services</a>          | Inpatient: No charge;<br>Outpatient: \$15 / visit                                                                                                                                                  | Not covered                                  | None                                                                                                                                                                                                                                    |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                 |                                              | Limitations, Exceptions, & Other Important Information |
|----------------------------------------|-------------------------------------------|---------------------------------------------------|----------------------------------------------|--------------------------------------------------------|
|                                        |                                           | Plan Provider<br>(You will pay the least)         | Non-Plan Provider<br>(You will pay the most) |                                                        |
|                                        | <a href="#">Habilitation services</a>     | Inpatient: No charge;<br>Outpatient: \$15 / visit | Not covered                                  | None                                                   |
|                                        | <a href="#">Skilled nursing care</a>      | No charge                                         | Not covered                                  | 100 day limit / benefit period.                        |
|                                        | <a href="#">Durable medical equipment</a> | No charge                                         | Not covered                                  | Subject to <a href="#">formulary</a> guidelines.       |
|                                        | <a href="#">Hospice services</a>          | No charge                                         | Not covered                                  | None                                                   |
| 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](#).)**

- |                                                                                                                                             |                                                                                                                                                                 |                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Children's glasses</li> <li>• Dental care (Adult and child)</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|

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

- |                                                                                                                                                |                                                                                                                                                                                      |                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture (20 visits limit/year combined with chiropractic)</li> <li>• Bariatric surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care (20 visits limit/year combined with acupuncture)</li> <li>• Hearing aids (\$1,000 limit / ear every 36 months)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Routine eye care (Adult)</li> </ul> |
|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|

**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](http://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:**

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

**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, kwijigo 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.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                                                 |      |
|-----------------------------------------------------------------|------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$15 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$0  |
| ■ Other (blood work) <a href="#">copayment</a>                  | \$0  |

#### 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$200        |
| Coinsurance                       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$260</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |      |
|-----------------------------------------------------------------|------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$15 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$0  |
| ■ Other (blood work) <a href="#">copayment</a>                  | \$0  |

#### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$600        |
| Coinsurance                       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$50         |
| <b>The total Joe would pay is</b> | <b>\$650</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |      |
|-----------------------------------------------------------------|------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$15 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$0  |
| ■ Other (x-ray) <a href="#">copayment</a>                       | \$0  |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$100        |
| Coinsurance                       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$100</b> |

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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 dispute resolution 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 dispute resolution 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](http://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.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).



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# 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. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

**Arabic:** نؤمن خدمات الترجمة الفورية مجاناً لك على مدار الساعة كافة أيام الأسبوع طوال ساعات العمل. بإمكانك طلب مساعدة المترجم الفوري للإجابة على كافة أسئلتك حول التغطية الصحية التي نقدمها. بالإضافة إلى ذلك، يمكنك طلب ترجمة الوثائق الطبية للغتك مجاناً. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجى الاتصال على الرقم (711).

**Armenian:** Մենք օրը 24 ժամ, շաբաթը 7 օր, մեր աշխատանքի բոլոր ժամերին Ձեզ համար անվճար բանավոր թարգմանչի ծառայություններ ենք տրամադրում: Թարգմանչի օգնությամբ Դուք կարող եք պատասխան ստանալ Ձեր հարցերին՝ մեր կողմից տրամադրվող առողջության ապահովագրության վերաբերյալ: Կարող եք նաև Ձեր լեզվով թարգմանված գրավոր նյութեր խնդրել, որոնք Ձեզ համար անվճար են: Պարզապես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711** համարով:

**Farsi:** ما خدمات مترجم شفاهی را در 24 ساعت شبانروز و 7 روز هفته در طول همه ساعات کاری بدون اخذ هزینه در اختیار شما قرار می دهیم. شما می توانید برای کمک در پاسخگویی به سوالات خود در مورد پوشش مراقبت درمانی ما از یک مترجم شفاهی بهره مند شوید. همچنین می توانید درخواست کنید که همه جزوات بدون اخذ هزینه به زبان شما ترجمه شوند. کفایت در 24 ساعت شبانروز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند

**Hindi:** हम संचालन के सभी घंटों के दौरान आपको बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन प्रदान करते हैं। आप हमारी स्वास्थ्य देखभाल कवरेज के बारे में आपके प्रश्नों के जवाब के लिए एक दुभाषिये की सहायता ले सकते हैं। आप बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए अनुरोध भी कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

**Hmong:** Peb muaj neeg txhais lus pub dawb rau koj, 24 teev ib hnuv twg, 7 hnuv ib lim tiam twg, thawm cov sij hawm qhib ua lag luam.Koj muaj tau ib tug neeg txhais lus los pab teb koj cov lus nug txog peb cov kev pab them nqi kho mob.Koj thov tau kom muab cov ntaub ntauv txhais uas koj hom lus pub dawb rau koj.Tsuas hu rau **1-800-464-4000**, 24 teev ib hnuv twg, 7 hnuv ib lim tiam twg (cov hnuv caiv kaw). Cov neeg siv TTY hu 711.

**Japanese:** 当院では、全診療時間を通じて、通訳サービスを無料で、年中無休、終日ご利用いただけます。当院の医療内容についてのご質問および回答には、通訳がお手伝いいたします。また、日本語に翻訳された資料を無料で請求できます。お気軽に **1-800-464-4000** までお電話ください (祭日を除き年中無休)。TTY ユーザーは 711 にお電話ください。

**Khmer:** យើងផ្តល់សេវានៃអ្នកបកប្រែ ដោយឥតអស់ថ្លៃដល់អ្នកឡើយ 24 ម៉ោង មួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ ក្នុងអំឡុងម៉ោងធ្វើការទាំងអស់។ អ្នកអាចមានអ្នកបកប្រែ ដើម្បីជួយឆ្លើយសំណួររបស់អ្នក អំពីការរាប់រងថែទាំសុខភាព របស់យើង។ អ្នកក៏អាច ស្នើសុំសំភារៈដែលបានបកប្រែជាភាសាខ្មែរ ដោយឥតអស់ថ្លៃដល់អ្នកដែរ។ គ្រាន់តែ ទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បើថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711** ។

**Korean:** 업무 시간 동안에는 요일 및 시간에 관계없이 통역 서비스를 무료로 이용하실 수 있습니다. 통역의 도움을 받아 건강 보험 혜택에 관하여 질문하고 답변을 들으실 수 있습니다. 또한, 귀하가 사용하는 언어로 번역된 자료를 요청해 무료로 제공받으실 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000**번으로 전화해 문의하십시오(공휴일 휴무). TTY 사용자 번호 **711**.

**Navajo:** Nihí ata' halne'é áká'adoolwołígíí nihei hóló t'áá jíík'é, t'áá naadiin díí' ahéé'iilkeedgo, tsosts'id yiskáąjį', ndá'anishgo ookił biyi' góné. Ata' halne'é níká'adoolwoł na'idikid nee hólóógo díí ats'íis baa áháyáá bik'éstí'ígíí biná'idíłkidgo. Áádóó áldó' naaltsoos lá t'áá ní nizaad k'ehji álnéehgo t'áá jíík'é ádoolníł. Nihích'i' hodíłnih kojį' **1-800-464-4000** jíįgo dóó t'ée' nidi, tsosts'id yiskáąjį' dimoo na'adleehjį' (Holidaysgo éi da'deelkaal) doo da'diits'a'ígíí chodayoof'ínígíí kojį' hodíłnih **711**

**Punjabi:** ਅਸੀਂ ਕਾਰਵਾਈ ਦੇ ਸਾਰੇ ਘੰਟਿਆਂ ਦੇ ਦੌਰਾਨ, ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਮੁਹੱਈਆ ਕਰਵਾਉਂਦੇ ਹਾਂ। ਤੁਸੀਂ ਸਾਡੀ ਸਿਹਤ ਦੇਖਭਾਲ ਕਵਰੇਜ ਬਾਰੇ ਆਪਣੇ ਸਵਾਲਾਂ ਦੇ ਜਵਾਬ ਲਈ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲੈ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਦੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

**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 pagsagot 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 (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

**Thai:** เรามีบริการสามฟรีสำหรับคุณตลอด 24 ชั่วโมง ทุกวันตลอดชั่วโมงทำการของเราคุณสามารถขอให้เราช่วยตอบคำถามของคุณที่เกี่ยวข้องกับความคุ้มครองการดูแลสุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสารเป็นภาษาที่คุณใช้ได้โดยไม่มีค่าธรรมเนียมการเพียงโทรหาเราที่หมายเลข **1-800-464-4000** ตลอด 24 ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้ TTY 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。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日休息）。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 thông dịch viên giúp 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. Chỉ cần gọi 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

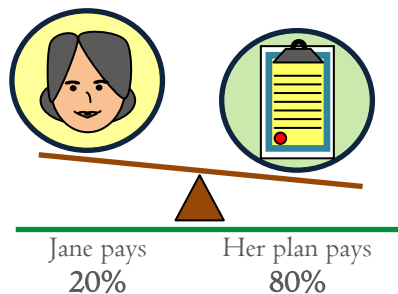
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you 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

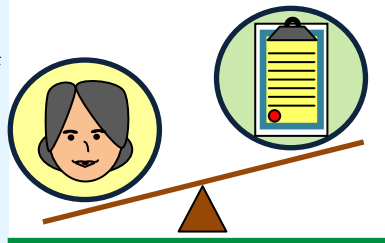
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) 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%      Her plan pays 0%  
(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](#).



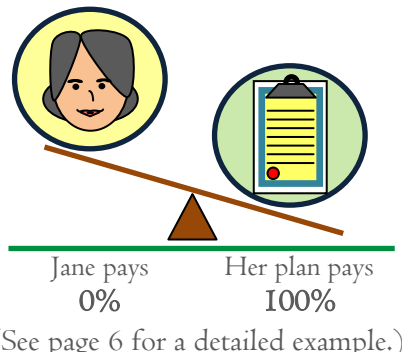
## Out-of-network Provider (Non-Preferred Provider)

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.

## 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

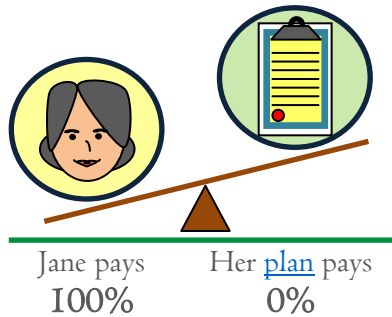
Jane's Plan Deductible: \$1,500

Coinsurance: 20%

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

January 1<sup>st</sup>  
Beginning of Coverage Period

December 31<sup>st</sup>  
End of Coverage Period



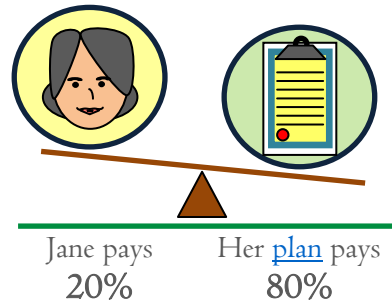
## Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0



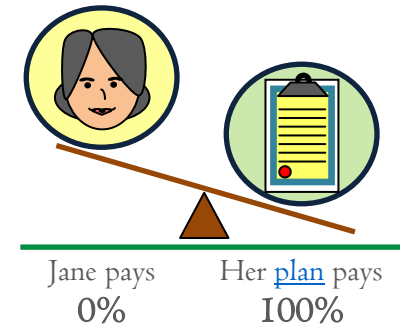
## Jane reaches her \$1,500 deductible, coinsurance begins

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