The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.anthem.com/ca/calpers. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (877) 737-7776 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$500/member or $1,000/family for In-Network Providers. $500/member or $1,000/family for Out-of-Network Providers.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription Drugs, Preventive care, Primary Care visit, and Specialist visit for In-Network Providers.</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>Yes. $50/visit for Emergency room services (waived if admitted directly from ER).</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$3,000/single or $6,000/family for In-Network Providers. No Out-of-Pocket limit when using Out-of-Network Providers. This plan has a separate Out of Pocket Maximum for Prescription Drugs $2,000/single or $4,000/family $1,000 Home delivery.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, Balance-Billing charges, and Health Care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes, Prudent Buyer PPO. See <a href="http://www.anthem.com/ca/calpers">www.anthem.com/ca/calpers</a> or call (877) 737-7776 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>
</tbody>
</table>
Do you need a referral to see a specialist?

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20/visit deductible does not apply</td>
<td>40% coinsurance</td>
<td>---none------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20/visit deductible does not apply</td>
<td>40% coinsurance</td>
<td>---none------</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>---none------</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>---none------</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>---none------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$5/30 day supply</td>
<td>Not Covered</td>
<td>After second fill you will pay the appropriate mail service copay for maintenance medications. 90 day supplies (OptumRx Select90 Saver) allowed at Walgreens and Home Delivery program.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$20/30 day supply $10/90 day supply</td>
<td>Not Covered</td>
<td>---none------</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$50/30 day supply $100/90 day supply</td>
<td>Not Covered</td>
<td>---none------</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Specialty follows the tier structure above</td>
<td>Not Covered</td>
<td>Certain Specialty Medications are available only through BriovaRx Specialty Pharmacy and are limited up to a 30-day supply.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee e.g. Ambulatory Surgery Center; ASC</td>
<td>Tier 1 Hospital 20% Coinsurance Tier 2 Hospital 30% Coinsurance</td>
<td>40% coinsurance</td>
<td>Services and supplies for the following outpatient surgeries are limited: Colonoscopy limited to $1,500 per procedure, Cataract surgery limited to $2,000 per procedure; Arthroscopy limited to $6,000 per procedure. Benefits limited to $350 for ASC per day for Non-PPO providers.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>---none------</td>
</tr>
<tr>
<td>If you need immediate</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>Covered as In-Network</td>
<td>If admitted directly to hospital $50 ER deductible waived.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at www.anthem.com/ca/calpers.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>medical attention</td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>Covered as In-Network</td>
<td>-------none--------</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20/visit deductible does not apply</td>
<td>40% coinsurance</td>
<td>-------none--------</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Tier 1 Hospital 20% Coinsurance Tier 2 Hospital 30% Coinsurance</td>
<td>40% coinsurance</td>
<td>Hip and Knee joint replacement surgery will be limited to $30,000 per procedure. A subset of participating hospitals meets this maximum benefit coverage. Pre-authorization required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>-------none--------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit $20/visit deductible does not apply Other Outpatient 20% coinsurance</td>
<td>Office Visit 40% coinsurance Other Outpatient 40% coinsurance</td>
<td>Office Visit -------none-------- Outpatient -------none--------</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Tier 1 Hospital 20% Coinsurance Tier 2 Hospital 30% Coinsurance</td>
<td>40% coinsurance</td>
<td>-------none--------</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>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>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Tier 1 Hospital 20% Coinsurance Tier 2 Hospital 30% Coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>45 visits/benefit period. A visit is defined as 4 hours or less.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>*See Therapy Services section in plan document.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance first 10 days 30% coinsurance following 90 days</td>
<td>40% coinsurance</td>
<td>Maximum 100 days per calendar year Pre-authorization required.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>-------none--------</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see [plan](https://www.anthem.com/ca/calpers) or policy document at [www.anthem.com/ca/calpers](https://www.anthem.com/ca/calpers).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>--------none--------</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>--------none--------</td>
</tr>
</tbody>
</table>

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
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes.
- Dental routine care (adult)
- Personal development programs
- Weight loss programs
- Infertility treatment
- Private-duty nursing

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

- Acupuncture 20 visits/benefit period.
- Hearing aids $1,000 maximum every 36 months.
- Bariatric surgery
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Chiropractic care 20 visits/benefit period.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: Grievance and Appeals 1-877-737-7776 or Anthem Blue Cross Attention: Grievance and Appeals P.O. Box 60007 Los Angeles, CA 90060-0007
If Anthem Blue Cross upholds the ABD, that decision becomes a Final Adverse Benefit Determination (FABD) and you may request an independent External Review. If you are not satisfied with Anthem Blue Cross’ FABD, the independent External Review decision or you do not want to pursue the independent External Review Process, you may request an Administrative Review from CalPERS.
The request must be mailed to: CalPERS Health Plan Administration Division/ Health Appeals Coordinator P.O. Box 1953 Sacramento, CA 95812-1953

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

________________________________________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 pre-natal 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>■ The plan’s overall deductible</td>
<td>$500</td>
<td>■ The plan’s overall deductible</td>
</tr>
<tr>
<td>■ Specialist copayment</td>
<td>$20</td>
<td>■ Specialist copayment</td>
</tr>
<tr>
<td>■ Hospital (facility) coinsurance</td>
<td>20%</td>
<td>■ Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>■ Other coinsurance</td>
<td>20%</td>
<td>■ Other coinsurance</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:

- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost** $12,840

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$80</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,480</td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $60

The total Peg would pay is $3,120

This EXAMPLE event includes services like:

- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost** $7,460

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$624</td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $31

The total Joe would pay is $2,355

This EXAMPLE event includes services like:

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

**Total Example Cost** $2,010

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$326</td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $0

The total Mia would pay is $886

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

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjihën tuaj. Për të kontaktuar me një përkthyes, telefononi (877) 737-7776

Amharic (አማርኛ): የወን ማሳ ከምርምርም ይሁን ከምርምርም ይህን ከምርምርም ይህን ከምርምርም ይህን ከምርምርም ይህን ከምርምርም ይህን ከምርምርም ይህን ከምርምርም ይህን ከምርምርም ይህን ከምርምርም ይህን ከምርምርም ይህን ከምርምርም (877) 737-7776 ከአማርኛ.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (877) 737-7776:


Bengali (বাংলা): যদি এই বিষয়ের বিষয়ে আপনার কোন প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিস্তারিত সাহায্য পাওয়ার ও জ্ঞান পাওয়ার অধিকার আপনার আছে। একজন দোকানীর সাথে কথা বলার জন্য (877) 737-7776 হেতে কল করুন।

Burmese (ကြားစောင်း)): သို့သော်လည်း မိုးဗျာစ်သော ပြောက်မှုသည် အကြမ်းဖက်အားဖြင့် အသုံးပြုသော လက်ရာများ အားလုံး အများစုသော လုပ်ငန်းများ အထူးသဖြင့် အချိန် သုံးစွဲသော လုပ်ငန်းများကို အများစုအပါ ဖော်ပြသည်။ (877) 737-7776 ရှိသည်။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (877) 737-7776。

Dinka (Dinka): Na nang thiicce nê ke de yâ thori, ke yin nang log bê yi kuony ku wer âleu bê gëez yic yin ne thong du ke cin wëu tásâe ke pinî. Te kor yin ba jam wëne ran ye thok gëyic, ke yin col (877) 737-7776.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (877) 737-7776.

Farsi (فارسی): در صورتی که سوالی پیرامون این سند دارید، این حق را دارید که اطلاعات و چگونه را بدون هیچ هزینه‌ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 737-7776 تماس بگیرید.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (877) 737-7776.
Language Access Services:

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (877) 737-7776.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (877) 737-7776.

Gujarati (ગુજરાતી): ત્યારે આ દસ્તાવેજ અંગે આપણે શુંપણી પ્રાણી દોખ તો, શુંપણી પરિસ્થિતિ વગર આપની ભાષામાં મહતિ અને મોડલેટ્સના મેળવવાની તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (877) 737-7776.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (877) 737-7776.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न है, तो आपको निष्क्रिय अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (877) 737-7776.

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nej. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (877) 737-7776.

Igbo (Igbo): Ọ bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gi na akwụghị ụgwọ ọ bụla. Ka gi na ọkọwa okwu kwuo okwu, kpọpọ (877) 737-7776.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (877) 737-7776.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (877) 737-7776.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (877) 737-7776.

Japanese (日本語): この文書についてならかげ不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(877) 737-7776 にお電話ください。

(877) 737-7776
Language Access Services:

Khmer (កម្ម): ពេញមួយចំនួនជកជាប់ក្នុងសារដែលនេះ។ ការបញ្ហាជាតិក្នុងសារដែលនេះមានការហៅលើក្រុមហ៊ុនការផ្ទាល់ប្រព័ន្ធវិញ្ញាប័ន។

Kirundi (Kirundi): Ugiez ikibazw cy'ariro an'ny andiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (877) 737-7776.

Korean (한국어): 본 문서에 대한 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (877) 737-7776로 문의하십시오.

Lao (ລາວ): ກ່ប່ວ ປ່ຽນ ກ່ຽວ ກັບ ການ ກັບ ເຮັດ ບ່ຽນ ຜູ ເຮັດ ເຮັດ ມີ ບ່ຽນ ທ່ານ ຄູ້ ເຮັດ ບ່ຽນ ທ່ານアラファ語, ໃຫ້ ສາມາລັດ (877) 737-7776.

Navajo (Diné): Díí náa tussoos biká’a’i gułhó biná’idilkidgo ná bohóóedzág dóó bee ahóót’í’ t’áá ni nízaad k’e’hí bee nlí hodoonih t’aadoo bááh ilinígóó. Ata’ halné’igíí la’ bichí’jí hadeeszhíh níningíng kojí hodiílníh (877) 737-7776.

Nepali (नेपाली): यदि आपके कान्जागरे तपाईं संग केही प्रश्न छूँ भने, आपके भाषामा निश्चित तपाईं गर्न सक्ने हुन्छ तपाईं संग छ। दोमाको लागि, यहूदी कल नगरीहरू (877) 737-7776.

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (877) 737-7776 bilbilla.


Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do безоплатного uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (877) 737-7776.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (877) 737-7776.

Punjabi (ਪੰਜਾਬੀ): ਸੀ ਟੂਰਾਡੀ ਦੀ ਟੇਮਬਰਡੀਜ਼ ਵਿੱਚ ਕੇਦੀ ਨਾਲ ਉੱਠਨ ਲਗੂ ਦਲ ਦੇ ਤੱਤੇ ਟੁੰਕਾ ਵੇਲ ਸੁਤਰ ਦੀ ਨਾਲ ਕੈਸ ਸੁਤਰ ਤੇ ਵੇਵ ਨਾਲ ਤੇ ਪ੍ਰਤਿਵਾਦ ਤੌਂ ਹੀ। ਦੀਕੀ ਟੁੰਕਾ ਦੀ ਨਾਲ ਵੇਲ ਬਾਲੋਟ ਸਕਦੀ (877) 737-7776 ਵਾਲੀ ਬੋਲਵੇ।
Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (877) 737-7776.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (877) 737-7776.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (877) 737-7776.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (877) 737-7776.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (877) 737-7776.

Tagalog (Tagalog): Kung mayroon kaang katanungan tungkol sa dokumentong ito, may karapatan kang gumiling ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (877) 737-7776.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (877) 737-7776 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): Якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зв'яжіться з нами по номеру (877) 737-7776.

Urdu (اردو): اگر اس دستاویز کی بارے میں آپ کا کوئی سوال ہے، یا آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنا ہے کا حق حاصل ہے۔ کسی مترجم سے بات کرنا چاہتا ہے؟

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (877) 737-7776.

Yiddish (אידיש):azi yeid velt shlayt un dem dreykumen, ka farve, de rute, un dem dreykumen. Avisa im a velt shlayt un dem dreykumen, ka farve, de rute, un dem dreykumen.

Yoruba (Yorùbá): Ti o mulo eyikeyi ibere nipa akọsilẹ yii, o ni eto lari gba iranwo ati iwifin ni ede re ìfọ́ẹ. Bá wa ogbọ́rú kan sọrọ, pe (877) 737-7776.
Language Access Services:

It's important we treat you fairly

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

- This glossary defines many commonly used terms, but isn’t a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

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

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

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

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

**Coinsurance**
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

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

**Copayment**
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

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

**Cost-sharing Reductions**
Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you’re a member of a federallyrecognized 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.
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

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**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

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**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

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**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