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, visit www.sharphealthplan.com/CalPERS or call 1-855-995-5004. 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.sharphealthplan.com/CalPERS or call Sharp Health Plan at 1-855-995-5004 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Medical: $1,500 Individual / $3,000 Family Pharmacy: $5,850 Individual / $11,700 Family / $1,000 Mail order</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. OptumRx serves as CalPERS’ pharmacy benefit manager.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, copayments for supplemental benefits (except prescription drugs), 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.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In Network Provider (You will pay the least)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>Acupuncture/Chiropractic: $15 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge/visit (blood work)</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge/procedure</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred generic drugs</td>
<td>$5/30-day supply $10/90-day supply</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$20/30-day supply $40/90-day supply</td>
</tr>
<tr>
<td></td>
<td>Non-preferred drugs</td>
<td>$50/30-day supply $100/90-day supply</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Specialty follows the tier structure above</td>
</tr>
<tr>
<td>More information about <a href="https://www.optumrx.com/calpers">prescription drug coverage</a> is available at <a href="http://www.optumrx.com/calpers">www.optumrx.com/calpers</a>. After second fill you will pay the appropriate mail service copay for maintenance medication. 90-day supply allowed at Walgreen's retail pharmacies and OptumRx Home Delivery. Certain Specialty Medications are available only through BriovaRx®, the OptumRx Specialty Pharmacy and are limited up to a 30-day supply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge/procedure</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge/visit</td>
</tr>
<tr>
<td>Preauthorization is required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$50 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge/trip</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15 copay/visit</td>
</tr>
<tr>
<td>Cost sharing waived if admitted to the hospital.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge/admission</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge/visit</td>
</tr>
<tr>
<td>Preauthorization is required for non-emergency services. Out-of-network services are covered for emergency care only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td></td>
<td>In Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Mental/Behavioral health outpatient office visits and group therapy</td>
<td>$15 <strong>copay</strong>/visit</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health other outpatient items and services</td>
<td>No charge/visit*</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient facility fee and inpatient physician fee</td>
<td>No charge/admission (facility fee); No charge/visit (physician fee)</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient office visits and group therapy</td>
<td>$15 <strong>copay</strong>/visit</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder other outpatient items and services</td>
<td>No charge/visit*</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient facility fee and inpatient physician fee</td>
<td>No charge/admission (facility fee); No charge/visit (physician fee)</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postpartum office visits</td>
<td>No charge/visit</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge/visit</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge/admission</td>
</tr>
</tbody>
</table>

*Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment, coinsurance, or deductible (if applicable) may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Out-of-network services are covered for emergency care only.*
## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

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

### If you need help recovering or have other special health needs

<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><strong>Home health care</strong></td>
<td>No charge/visit</td>
<td>Not covered</td>
<td>Preauthorization is required. Coverage is limited to short-term, intermittent services, 100 visits/calendar year.</td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong></td>
<td>$15 copay/visit</td>
<td>Not covered</td>
<td>Preauthorization is required. Includes physical therapy, speech therapy, and occupational therapy.</td>
<td></td>
</tr>
<tr>
<td><strong>Habilitation services</strong></td>
<td>Not charge/admission</td>
<td>Not covered</td>
<td>Preauthorization is required.</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled nursing care</strong></td>
<td>No charge/admission</td>
<td>Not covered</td>
<td>Preauthorization is required. Coverage is limited to 100 days/calendar year.</td>
<td></td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td>No charge</td>
<td>Not covered</td>
<td>Preauthorization is required.</td>
<td></td>
</tr>
</tbody>
</table>
| **Hospice services**                  | Inpatient: No charge/admission  
Outpatient: No charge/visit           | Not covered                                 | Preauthorization is required. |

### If your child needs dental or eye care

<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><strong>Children’s eye exam</strong></td>
<td>No charge/visit</td>
<td>Not covered</td>
<td>Eye exams are covered once every 12 months. Cost sharing for covered supplemental vision services do not count towards the out-of-pocket limit.</td>
<td></td>
</tr>
<tr>
<td><strong>Children’s glasses</strong></td>
<td>No charge</td>
<td>Not covered</td>
<td>Eyeglasses or contact lenses (following cataract surgery). Cost sharing for covered supplemental vision services do not count towards the out-of-pocket limit.</td>
<td></td>
</tr>
<tr>
<td><strong>Children’s dental check-up</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

---

**CalPERS Sharp Performance Plus HMO**
### 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.)**

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetic Surgery</td>
</tr>
<tr>
<td>Dental Care (Adult and Child)</td>
</tr>
<tr>
<td>Habilitation Services</td>
</tr>
<tr>
<td>Long Term Care</td>
</tr>
<tr>
<td>Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
</tr>
<tr>
<td>Routine Foot Care</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
</tr>
<tr>
<td>Chiropractic Care</td>
</tr>
<tr>
<td>Hearing Aids</td>
</tr>
<tr>
<td>Infertility Treatment (including Artificial Insemination)</td>
</tr>
<tr>
<td>Routine eye care (Adult and Child)</td>
</tr>
<tr>
<td>Weight Loss Programs</td>
</tr>
</tbody>
</table>

### 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 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html. 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: California Department of Managed Health Care at 1-888-466-2219 or www.hmohelp.ca.gov, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/healthreform.

### 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 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:

English
If you, or someone who you are helping, has questions about Sharp Health Plan, you have the right to obtain help and information in your language without any cost to you. To speak with an interpreter, call 1-855-995-5004.

Español (Spanish)
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Sharp Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-995-5004.

繁體中文 (Chinese)
如果您，或是您正在協助的對象，有關Sharp Health Plan的問題，您有權免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-855-995-5004。

Tiếng Việt (Vietnamese)
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Sharp Health Plan, quý vị sẽ có quyền được giúp và có thể thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một tổ chức dịch vụ, xin gọi 1-855-995-5004.

Tagalog (Tagalog – Filipino)
Kung ikaw, o ang iyong tunutulangan, ay may mga katanungan tungkol sa Sharp Health Plan, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-995-5004.

한국어(Korean)
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Sharp Health Plan에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-995-5004로 전화하십시오.

Հայերեն (Armenian)
Եթե Դուք կամ Ձեր կողմից օգնող ուղեկցության հետ կապված հարցեր ունեք Sharp Health Plan մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու մասին։ Թարգմանիչ հետ կապվելու համար կատարեք 1-855-995-5004:

Persian
کم که دارید را این حق باشید داشته، که شما شما که که کسی یا شما کسی، اگر Sharp Health Plan مورد در سوال، می‌کنید کمک آور و یا به شما که کسی یا شما کسی، نمایند حاصل تماس 404-955-5004، 1 نمایند دریافت رایگان طور به را خود زبان به اطلاعات و.
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Sharp Health Plan: CalPERS Sharp Performance Plus HMO

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

Coverage for: Individual / Family | Plan Type: HMO

What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2018 – 12/31/2018

Sharp Health Plan: CalPERS Sharp Performance Plus HMO

Русский (Russian)
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Sharp Health Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-995-5004.

日本語 (Japanese)
ご本人様、またはお客様の身の回りの方でも、Sharp Health Planについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-855-995-5004までお電話ください。

العربية (Arabic)
والمعلومات المساعدة على الحصول في الحق فنديك ، Sharp Health Plan بكخصوص أسئلة تساءله شخص لدى أرليك كان إن 1-855-995-5004 1 ( ب اتصل مترجم مع للتحدث تكافهة أية دون من بعلتك الضرورية.

ਪੰਜਾਬੀ (Punjabi)
ਨੇ ਉਸਦਾ ਕੁਝ ਨਾਮ ਤੇ ਅਸਾਧਾਰਣ ਵਾਲਾ ਜਾਰੀ ਕਰਨ ਦੀ ਪ੍ਰਮਾਣ ਦਾ ਪ੍ਰਸਤਾਵ ਹੈ , Sharp Health Plan ਵੇਲੀ ਮਾਲਕ ਦੀ ਤਰ੍ਹਾਂ ਪ੍ਰਤੀ ਕਿਸੇ ਜਾਨ ਬਾਰੇ ਤਕਰਕਾਂ ਦੁਆਰਾ ਅਧਿਕਾਰੀ ਹੈ . ਹੁਣ ਆਪਣਾ ਤੁਹਾਣੇ ਦੁਆਰਾ ਕਾਫੀ ਲੱਕਣ ਗਾਲਬਾਂ ਹੋਣਾ, 1-855-995-5004 ਨੂੰ ਕਲਰ ਵਾਰਨ.

Mon Khmer, Cambodian)
ការបោះជំនួសការជួសជាប់ការបង្កើតសំរួលបំផុត៖ Sharp Health Plan ។ អ្នកបានរៀបចំការបង្កើតបំផុត៖ ការសិក្សាខាងក្រៅ និងការបោះជំនួសជាប់ការបង្កើតបំផុត៖ 1-855-995-5004 ។

Hmong (Hmoob)
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Sharp Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau uj koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-855-995-5004.

हिंदी (Hindi)
यदि आपके, या आप दुसरा सहायता किए जा रहे किसी व्यक्ति के Sharp Health Plan के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुर्भाग्य से बात करने के लिए, 1-855-995-5004 पर कॉल करें।

ภาษาไทย (Thai)
หากคุณ หรือคนที่คุณช่วยเหลือมีคำถามเกี่ยวกับ Sharp Health Plan คุณมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณโดยไม่ต้องเสียค่าใช้จ่าย พบครูที่มี โทร 1-855-995-5004
Section 1557 Nondiscrimination Notice

Sharp Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (such as large print, audio, accessible electronic formats, or other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Jamie Ryan, Director of Operations at (858) 499-8275. If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Sharp Health Plan
Appeal/Grievance Department
Attn: Jamie Ryan, Director of Operations
8520 Tech Way, Suite 200
San Diego, CA 92123-1450
Toll-free: 1-855-995-5004
1-800-735-2929 TTY
Fax: (619) 740-8572

You can file a grievance in person or by mail, fax, or you can also complete the online Grievance/Appeal form on the Plan’s website sharphealthplan.com. If you need help filing a grievance, Jamie Ryan, Director of Operations is available to help you. 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 [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).


To see examples of how this plan might cover costs for a sample medical situation, see the next section.
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

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

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 differ depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

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

Total Example Cost | $12,800 | $7,400 | $1,900

In this example, Peg would pay:
<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$100</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

In this example, Mia would pay:
<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$600</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

In this example, Joe would pay:
<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$600</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions $0

The plan would be responsible for the other costs of these EXAMPLE covered services.
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 cesarean 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

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