The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.anthem.com/ca/calpers/hmo. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 839-4524 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$1,500/single or $3,000/family for In-Network Providers. No Out Of Pocket Limit when using Non-HMO Providers. This plan has a separate Out of Pocket Maximum for Prescription Drugs $6,400/individual or $12,800/family, $1,000 Home delivery.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Infertility services, Premiums, Balance-Billing charges, and Health Care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.anthem.com/ca/calpers/hmo">www.anthem.com/ca/calpers/hmo</a> or call (855) 839-4524 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>

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.
<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><strong>Primary care visit to treat an injury or illness</strong> $15/visit</td>
<td>Not covered</td>
<td>--------none--------</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit $15/visit</td>
<td>Not covered</td>
<td>--------none--------</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization No charge</td>
<td>Not covered</td>
<td>--------none--------</td>
<td>--------none--------</td>
</tr>
<tr>
<td>If you have a test</td>
<td><strong>Diagnostic test (x-ray, blood work)</strong> No charge</td>
<td>Not covered</td>
<td>--------none--------</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs) No charge</td>
<td>Not covered</td>
<td>--------none--------</td>
<td>--------none--------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td><strong>Generic drugs</strong> $5/30 day supply $10/90 day supply</td>
<td>Not Covered 100% Out-of-Pocket</td>
<td></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>Brand name formulary drugs $20/30 day supply $40/90 day supply</td>
<td>Not Covered 100% Out-of-Pocket</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brand name non-formulary drugs $50/30 day supply $100/90 day supply</td>
<td>Not Covered 100% Out-of-Pocket</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs Specialty follows the tier structure above</td>
<td>Not Covered 100% Out-of-Pocket</td>
<td></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>No charge</td>
<td>Not covered</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees No charge</td>
<td>Not covered</td>
<td>--------none--------</td>
<td>--------none--------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td><strong>Emergency room care</strong> $50/visit Covered as In-Network</td>
<td>If admitted inpatient, ER copay is waived.</td>
<td></td>
<td>Out-of-network only covered when out of area. For in area, contact your PCP or medical group.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation No charge Covered as In-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care $15/visit Covered as In-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room) No charge Not covered</td>
<td>--------none--------</td>
<td>--------none--------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees No charge Not covered</td>
<td>--------none--------</td>
<td>--------none--------</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at [https://eoc.anthem.com/eocdps/ca/fi](https://eoc.anthem.com/eocdps/ca/fi).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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</tr>
</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit $15/visit Other Outpatient No charge</td>
<td>Office Visit Not covered Other Outpatient Not covered</td>
<td>Office Visit --------- none------ Other Outpatient --------- none------</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
<td>--------- none------</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</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>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
<td>--------- none------</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15/visit</td>
<td>Not covered</td>
<td>*See Therapy Services section in Evidence of Coverage.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15/visit</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
<td>100 days limit/benefit period.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
<td>--------- none------</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
<td>--------- none------</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge</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>

* For more information about limitations and exceptions, see plan or policy document at [www.anthem.com/ca/calpers/hmo](http://www.anthem.com/ca/calpers/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.)

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

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

- Acupuncture Rider 20 visits/benefit period combined with Chiropractic care.
- Hearing aids per ear/every 3 years.
- Bariatric surgery
- Routine eye care (adult) one visit/benefit period.
- Chiropractic care Rider 20 visits/benefit period combined with Acupuncture. Most coverage provided outside the United States. See www.bcbsglobalcore.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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:

Anthem Blue Cross 1-855-839-4524 P.O. Box 60007 Los Angeles, CA 90060-0007 Attn: CalPERS Grievance and Appeal Management

Additionally, a consumer assistance program can help you file your appeal. Contact: California Department of Managed Health Care Help Center 980 9th Street, Suite 500 Sacramento, CA 95814 (888) 466-2219 http://www.healthhelp.ca.gov helpline@dmhc.ca.gov

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.
### 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 **plan’s overall deductible** $0
- **Specialist copayment** $15
- **Hospital (facility) coinsurance** 0%
- **Other coinsurance** 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)*

**Total Example Cost** $12,840

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Peg’s Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$70</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td>$60</td>
</tr>
</tbody>
</table>

**The total Peg would pay is** $130

#### Managing Joe’s type 2 Diabetes

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

- The **plan’s overall deductible** $0
- **Specialist copayment** $15
- **Hospital (facility) coinsurance** 0%
- **Other coinsurance** 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)*

**Total Example Cost** $7,460

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Joe’s Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$3,670</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td>$21</td>
</tr>
</tbody>
</table>

**The total Joe would pay is** $3,691

#### Mia’s Simple Fracture

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

- The **plan’s overall deductible** $0
- **Specialist copayment** $15
- **Hospital (facility) coinsurance** 0%
- **Other coinsurance** 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)*

**Total Example Cost** $2,010

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Mia’s Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$255</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td>$47</td>
</tr>
</tbody>
</table>

**The total Mia would pay is** $255

---

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

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

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

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજનું અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહહતી મેળવવાનો તમને અભિવધિ છે. તેમ સાથે વાત કરવા માટે, કોલ કરો (855) 839-4524.

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

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न हैं, तो आपको निष्कृत अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है।

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

**Igbo (Igbo):** Ìbụrụ na ị nwere ajụjụ ọ bụla Ọbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi ịn'sịụ ị ga akwụghị ịgwọ ọ bụla. Ka ị ga ọkwọ okwu kwuo ọkwụ, kpọọ (855) 839-4524.

**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 (855) 839-4524.

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

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

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

Khmer (ខ្មែរ): ពេញប្រៀបធៀបទៅទៅងារអ្នកអំពីការសិក្សានេះ: ទូរស័ព្ទទំនុកជាតិវិញទៅលើអ្នកប្រឈមជាតិខ្មែរ។ ទូរស័ព្ទទំនុកជាតិរុករក (855) 839-4524។

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

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

Lao (ລາວ): អក្សរសាធារណ៍ឈើណ៍នៃអក្សរសាធារណ៍ខាងលើ ឈើជាមិនអាចកើតខ្លួនបាន ឬត្រូវការលើប្រកបដោយការធ្វើការដ៏ប្រសិនបើអ្នកប្រឈមការយល់ដៃនៃអក្សរសាធារណ៍ខាងលើ។ មើលលើទំនុកជាតិរុករក (855) 839-4524.

Navajo (Diné): Dií naaltsoos biká’iigíí lahay bina’dilkidgo ná bohóóezadó dóó bee ahóó’t’i’ t’áá ni nízaad ke’he’é bee nił hodoonih táadoó baáh ilínígóó. Ata’ halné’igíí la’ bich’í’ hadeesdzihin nímezíngí ko’jí hodiilnính (855) 839-4524.

Nepali (नेपाली): यदि यो कागजातको तपाईँंसंग केही प्रश्न हुने, अपने भाषा निश्चित सहयोग तथा जानकारी प्राप्त गर्न पाउने तपाईँंसंग छ। दोभाषीत्व कुरा गर्नका लागि, यहाँ कल गर्निहो (855) 839-4524.

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


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

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

Punjabi (ਪੰਜਾਬੀ): ਨੇ ਤੁਹਾਡੀ ਲਿਸਟ ਦੱਸਦਾ ਦਾ ਹਾਸੀ ਲਾਂਗ ਦੇ ਹਲ ਤੁਹਾਡੀ ਲਿਸਟ ਦੱਸਦਾ ਹਾਸੀ ਲਾਂਗ ਦੇ ਹਲ ਤੁਹਾਡੀ ਪ੍ਰਵਾਸਨੀ ਮਜ਼ਬੂਤ ਵਹਿਤ ਦੇ ਅਧਿਆਪਕ ਪੁੱਛ ਲੈ। ਲਿਸਟ ਦੱਸਦਾ ਲਾਂਗ ਦੇ ਹਾਸੀ ਲਾਂਗ ਦੇ ਹਲ (855) 839-4524 ਲੈ ਕਾਲੋ ਲੈ।
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 (TTY: 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 has 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. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such 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.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

**Allowed Amount**
Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

**Appeal**
A request for your health insurer or **plan** to review a decision or a **grievance** again.

**Balance Billing**
When a **provider** bills you for the difference between the provider’s charge and the **allowed amount**. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may not balance bill you for covered services.

**Co-payment**
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.

**Deductible**
The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. 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. The deductible may not apply to all services.

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

**Emergency Medical Condition**
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

**Emergency Medical Transportation**
Ambulance services for an **emergency medical condition**.

**Emergency Room Care**
**Emergency services** you get in an emergency room.

**Emergency Services**
Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

**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 aren’t complications of pregnancy.
**Excluded Services**
Health care services that your health insurance or plan doesn’t pay for or cover.

**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 your health insurer to pay some or all of your health care costs in exchange for a premium.

**Home Health Care**
Health care services a person receives at home.

**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. An overnight stay for observation could be outpatient care.

**Hospital Outpatient Care**
Care in a hospital that usually doesn’t require an overnight stay.

**In-network Co-insurance**
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

**In-network Co-payment**
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 co-payments usually are less than out-of-network co-payments.

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

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

**Non-Preferred Provider**
A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers.

**Out-of-network Co-insurance**
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

**Out-of-network Co-payment**
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 co-payments usually are more than in-network co-payments.

**Out-of-Pocket Limit**
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn’t cover. Some health insurance or plans don’t count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

**Physician Services**
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.
Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

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

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also “participating” providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

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.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

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

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

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

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility 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.

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.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

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

January 1st
Beginning of Coverage Period

Jane pays 100%
Her plan pays 0%

Jane hasn’t reached her $1,500 deductible yet
Her plan doesn’t pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

December 31st
End of Coverage Period

Jane reaches her $1,500 deductible, co-insurance begins
Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.
Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

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: $200
Jane pays: $0
Her plan pays: $200