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 blueshieldca.com/policies or call 1-800-257-6213. 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 healthcare.gov/sbc-glossary or call 1-866-444-3272 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>$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>Yes. Preventive care and other services listed in your complete terms of coverage.</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 healthcare.gov/coverage/preventive-care-benefits/.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. Prescription drugs -- $50 per individual/ $150 per family. There are no other specific deductibles.</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>$1,500 per individual /$4,500 per family.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Copayments for certain services, premiums, 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 blueshieldca.com/fap or call 1-800-257-6213 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>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Plan Provider (You will pay the least)</th>
<th>Non-Plan Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a healthcare provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15/visit</td>
<td>Not covered</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Access+ specialist: $30/visit Other specialist: $15/visit</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

<p>| <strong>If you have a test</strong> | Diagnostic test (x-ray, blood work) | Lab &amp; Path: No Charge X-Ray &amp; Imaging: No Charge Other Diagnostic Examination: No Charge | Lab &amp; Path: Not Covered X-Ray &amp; Imaging: Not Covered Other Diagnostic Examination: Not Covered | The services listed are at a free standing location. <strong>Preauthorization</strong> is required. Failure to obtain <strong>preauthorization</strong> may result in reduction or non-payment of benefits. |
| | Imaging (CT/PET scans, MRIs) | Outpatient Radiology Center: No Charge Outpatient Hospital: No Charge | Outpatient Radiology Center: Not Covered Outpatient Hospital: Not Covered | <strong>Preauthorization</strong> is required. Failure to obtain <strong>preauthorization</strong> may result in reduction or non-payment of benefits. |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Plan Provider (You will pay the least)</td>
<td>Non-Plan Provider (You will pay the most)</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1</td>
<td>Retail: $10/prescription</td>
<td>Retail: Not Covered</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at blueshieldca.com/formulary</td>
<td>Mail Service: $20/prescription</td>
<td>Mail Service: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>Retail: $25/prescription</td>
<td>Retail: Not Covered</td>
</tr>
<tr>
<td></td>
<td>Mail Service: $50/prescription</td>
<td>Mail Service: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>Retail: $50/prescription</td>
<td>Retail: Not Covered</td>
</tr>
<tr>
<td></td>
<td>Mail Service: $100/prescription</td>
<td>Mail Service: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4 (excluding Specialty drugs)</td>
<td>Retail: $50/prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Mail Service: $100/prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Ambulatory Surgery Center: $50/surgery</td>
<td>Ambulatory Surgery Center: Not Covered</td>
</tr>
<tr>
<td></td>
<td>Outpatient Hospital: $50/surgery</td>
<td>Outpatient Hospital: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>Facility Fee: $75/visit</td>
<td>Facility Fee: $75/visit</td>
</tr>
<tr>
<td></td>
<td>Physician Fee: No charge</td>
<td>Physician Fee: No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>Within Plan Service Area: $15/visit</td>
<td>Within Plan Service Area: Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outside Plan Service Area: $15/visit</td>
<td>Outside of Plan Service Area: $15/visit</td>
</tr>
</tbody>
</table>
|                      | | | | | Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>Plan Provider (You will pay the least): $100/admission</td>
<td>Non-Plan Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office Visit: $15/visit &lt;br&gt; Outpatient Services: No Charge &lt;br&gt; Partial Hospitalization: No Charge &lt;br&gt; Psychological Testing: No Charge</td>
<td>Office Visit: Not Covered &lt;br&gt; Outpatient Services: Not Covered &lt;br&gt; Partial Hospitalization: Not Covered &lt;br&gt; Psychological Testing: Not Covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Physician Inpatient Services: No Charge &lt;br&gt; Hospital Services: $100/admission &lt;br&gt; Residential Care: $100/admission</td>
<td>Physician Inpatient Services: Not Covered &lt;br&gt; Hospital Services: Not Covered &lt;br&gt; Residential Care: Not Covered</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$100/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Office Visit: No charge &lt;br&gt; Outpatient Hospital: No charge</td>
<td>Office Visit: Not Covered &lt;br&gt; Outpatient Hospital: Not Covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan Provider</td>
<td>Non-Plan Provider</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Office Visit:</td>
<td>Office Visit: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient Hospital:</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>Freestanding SNF:</td>
<td>Freestanding SNF:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital-based SNF:</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</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>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or cciio.cms.gov. 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 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: 1-800-257-6213 or the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/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 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.

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Language Access Services

English: For assistance in English at no cost, call 1-866-346-7198
Navajo (Dine): Diné k'éiih dís bágh ilínígó shíka' a'tooowol nínìnggo, kwíijí hodíílínih 1-866-346-7198.
Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.
Armenian (Հայերեն): Հայերենով զերծինակալագրի համար կատարեք կոմս 1-866-346-7198.
Russian (Русский): Если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.
Japanese (日本語): 日本語支援が必要な場合、1-866-346-7198 に電話かけてください。
無料で提供します。
Persian (فارسی): برای دریافت کمک رایگان زبان فارسی لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.
Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿੱਚ ਮੁੱਖ ਮੰਤਰੀ ਕਰਕੇ 1-866-346-7198 ਦੀ ਤਰੀਕੇ ਦੇ ਵਿਚ ਕਿੱਡ ਕਰ।
Hmong (Hmoob): Xav tau kev pab dawb lub Hmoob, thov hau rau 1-866-346-7198.
Hindi (हिंदी): हिन्दीमें खार्देयताके लिए, 1-866-346-7198 परकॉल करें।
Thai (ไทย): ที่บริการช่วยเหลือเป็นภาษาไทยให้ฟรีที่ 1-866-346-7198.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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 Plan pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s Type 2 Diabetes (a year of routine Plan care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (Plan emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$0</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$15</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$0</td>
<td>Hospital (facility) copayment</td>
</tr>
<tr>
<td>Other copayment</td>
<td>$0</td>
<td>Other copayment</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)*

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)*

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**

Peg Is Having A Baby $12,800  
Managing Joe’s Type 2 Diabetes $7,400  
Mia’s Simple Fracture $2,500

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

| Cost Sharing | Deductibles | $0  
| Copayments | $60  
| Coinsurance | $0  

**What isn’t covered**

Limits or exclusions $60  
**The total Peg would pay is** $120

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

| Cost Sharing | Deductibles | $0  
| Copayments | $735  
| Coinsurance | $0  

**What isn’t covered**

Limits or exclusions $1,783  
**The total Joe would pay is** $2,518

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

| Cost Sharing | Deductibles | $0  
| Copayments | $370  
| Coinsurance | $18  

**What isn’t covered**

Limits or exclusions $37  
**The total Mia would pay is** $425

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

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Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California 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:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator 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 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
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at 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.

Jane pays 100%  Her plan pays 0%

(See page 4 for a detailed example.)
**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

more costs

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

more costs

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

more costs