## Summary of Benefits and Coverage

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](http://www.anthem.com/ca/calpers) For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-759-5758 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>$2,000/member or $4,000/family for In-Network Providers, $0/member or $0/family for Out-of-Network Providers. This plan has a separate Out of Pocket Maximum for Prescription Drugs $5,900/member or $11,800/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>Prescription Drugs, Premiums, Balance-Billing charges, and Health Care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes, Prudent Buyer PPO. See <a href="http://www.anthem.com/ca/calpers">www.anthem.com/ca/calpers</a> or call 1-800-759-5758 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>No.</td>
<td>You can see the specialist you choose without a referral.</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 visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $15/visit</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: $15/visit $40% coinsurance</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><strong>In-Network Provider (You will pay the least)</strong>: $15/visit $10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: $15/visit $40% coinsurance</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $5/30 day supply $10/90 day supply</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand drugs</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: $5/30 day supply $10/90 day supply</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Brand drugs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $20/30 day supply $40/90 day supply</td>
</tr>
<tr>
<td></td>
<td>Specialty follows the tier structure above</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: $20/30 day supply $40/90 day supply</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $5/30 day supply $10/90 day supply</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: $5/30 day supply $10/90 day supply</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 immediate medical attention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>Emergency room care</td>
<td>$50/visit then 10% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$15/visit</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>$540/admission</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Office Visit 10% coinsurance</td>
<td>Office Visit 40% coinsurance</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Office Visit 10% coinsurance</td>
<td>Other Outpatient 40% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>$540/admission</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</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>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) |
|---|---|---|
| • Cosmetic surgery | • Dental care (adult) | • Infertility treatment |
| • Long-term care | • Private-duty nursing | • Routine eye care (adult) |
| • 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.):

<table>
<thead>
<tr>
<th>Other Covered Services</th>
<th>Limitations</th>
<th>United States <a href="http://www.bcbs.com/bluecardworldwide">www.bcbs.com/bluecardworldwide</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Abortion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Acupuncture 20 visits/benefit period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bariatric surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chiropractic care 20 visits/benefit period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hearing aids up to $1,000 every 36 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Most coverage provided outside the United States <a href="http://www.bcbs.com/bluecardworldwide">www.bcbs.com/bluecardworldwide</a></td>
<td></td>
<td></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 (866) 444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Anthem Blue Cross (in writing within 60 days of notice of denial) P.O. Box 60007 Los Angeles, CA 90060-0007 Attn: CAHP Unit

If Anthem Blue Cross affirms the denial the following steps apply:

**STEP 2:** Special Review Procedures for Denial of Experimental or Investigational Treatment

**STEP 3:** Independent External Review

**STEP 4:** Administrative Appeal Process

**STEP 5:** Binding Arbitration (or Small Claims Court)

Does this plan provide Minimum Essential Coverage? Yes

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#), and [coinsurance](#)) and [excluded services](#) under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow-up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The <strong>plan’s overall deductible</strong></td>
<td>$0</td>
<td>The <strong>plan’s overall deductible</strong></td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td>$15</td>
<td><strong>Specialist copayment</strong></td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td>10%</td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td>10%</td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td><strong>Total Example Cost</strong></td>
<td>$12,840</td>
<td><strong>Total Example Cost</strong></td>
</tr>
<tr>
<td><strong>In this example, Peg would pay:</strong></td>
<td></td>
<td><strong>In this example, Joe would pay:</strong></td>
</tr>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
<td><strong>Deductibles</strong></td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$70</td>
<td><strong>Copayments</strong></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$1,242</td>
<td><strong>Coinsurance</strong></td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
<td><strong>What isn’t covered</strong></td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td>$60</td>
<td><strong>Limits or exclusions</strong></td>
</tr>
<tr>
<td><strong>The total Peg would pay is</strong></td>
<td>$1,372</td>
<td><strong>The total Joe would pay is</strong></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)

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

(TTY/TDD: 711)

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

Amharic (አማርኛ): የአማርኛCHA ከስለዚህ ያስፈልገው ከስለዚህ ቤት, ከምርሳንንም ቤት ለስለዚህ ይለሆ ይሰወል ይህ ከማይለመርሳት SANAW ከስለዚህ ለእርዳታ (877) 737-7776 ይልክል።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 776-737.

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


Bengali (বাংলা): যদি এই দেখিতেন্তের বিষয়ে আপনার কোন প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও ভাষা পাওয়ার অধিকার আপনার আছে। একজন দোকানীর সাথে কথা কথায় জল্লুন (877) 737-7776 -তে কল করুন।

Burmese (မြန်မာ): သင့်တွင်ပါဝင်သော စာလိုက်များကို ဖော်ပြမှုများ အလွန်ကြီးကြပ် ရွေးခေါ်ရန် အသိအမှတ်အရှင် အသို့များအနေဖြင့် အခြေခံများ ထောက်ပံ့နိုင်ပါသည်။ အတူမျှဝေပါ။ (877) 737-7776 ထုံးစံပါ။

Chinese (中文): 如果您对本文件有任何疑问，您有权限使用您的语言免费获得帮助和资讯。如需与译员通话，请致电 (877) 737-7776。

Dinka (Dinka): Na nong thiêe nê ke de yá thorë, ke yin nong loŋ bë yi kuony ku wer akë bë geër yic yin ne thon du ke cin wëu ūt àn ke pìny. Te kor yin ba jam wënë ran ye thok getyi, ke yin col (877) 737-7776.

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

Farsi (فارسی): در صورتی که سوالی پیرامون این سنند داردید، این حق را دارید که اطلاعاتی که در یک طرح به دست نخواهید گرفت در مهمی‌ای به زبان مادریتان دریافت نکنید. برای گفتگوی یک مترجم شفاهی، با شماره 737-7776 (877) تماس بگیرید.

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

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

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

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપણે કોઈપણ પ્રશ્નો હોય તો, કોઈપણ બધા આપની ભાષામાં મદદ અને માહહતી મેળવવા તમને અધિકાર છે. દુભાષયા સાથે બાત કરવા માટે, કોલ કરો (877) 737-7776.

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

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

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

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

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

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

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

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

Khmer (ភាសាខ្មែរ): ប្រសិនបើការងារពីដំណើរការមានសេវាអន្តរជាតិលើកឡើងជាមួយអ្នកមកពីភាសាខ្មែរ អាចទាញយកសេវាអន្តរជាតិដោយមានតំណាងក្នុងតារាងផ្សេងៗឬ ការទិញការជួយគេហទ្រូសានដោយមានតំណាងក្នុងតារាងផ្សេងៗ បានរៀបរាប់ប្រកបដោយ (877) 737-7776 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (877) 737-7776.

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

Lao (ພາສາລາວ): គ្មានប្រយោគាក់ដឹងទៅលើកិច្ចការការប្រការមួយនេះ ក៏មិនអាចទទួលបាននោះដោយគ្នានោះទៀតដោយ ពេលវេលាឬបេបារាមាត្រការប្រការរបស់អ្នក។ ទើបទទួលបានការប្រការប្រការឯភាព និងភាពយន្ត (877) 737-7776.

Navajo (Diné): Díí naaltsos biká’igií lahom bina’idilkidgo ná bohonéedzá dóó bee ahót’i’ t’áá ni níaaad k’ehjí bee niil hodoonih t’áadoó báah ilinigóó. Ata’háalne’igíí la’híchí’é’ hadeezdihziniiningkot’ojį’ hodiilnih (877) 737-7776.

Nepali (संस्कृत): यदि आप कामज़ाताबाजी तथ्यांसंग केही प्रश्न छन् भने, आफ्ने भाषामा निश्चित सहयोग तथा जानकारी प्राप्त गर्न पाउने हुकू तथ्यांसंग छ। दोआयासंग खुल्द गर्नका लागि, यीथौँ कल गुरुम्हस्ट्रॉस (877) 737-7776

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


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

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

Punjabi (ਪੰਜਾਬੀ): ਮੇਰੀਆਂ ਦੀਆਂ ਦਸਤਾਵੇਜ਼ ਦੀਆਂ ਵੇਲੇ ਤੁਹਾਡੀ ਦਸਤਾਵੇਜ਼ ਦੁੱਟੇ ਦਾ ਉਟ੍ਹਾਣ ਵੇਲ ਹੁੰਦਾ ਹੈ ਅਨੁਸਾਰ ਕੁਝ ਅਲਾਇਮ ਦੁੱਟੁੰਡ ਦੀਆਂ ਹਸਤਾਲੀ ਪ੍ਰਭਾਵ ਵਾਲੀ ਦਸਤਾਵੇਜ਼ ਦੀਆਂ ਵੇਲੇ ਅਧਿਆਵਧੀ ਕੁਝ ਹੁੰਦਾ ਹੈ। ਹੀਉ ਹੁੰਦਾ ਹੈ ਕਿ ਤੁਹਾਡੀ ਦਸਤਾਵੇਜ਼ ਦੀ ਤਰਜ਼ ਵਾਲੀ ਸਹਿਯੋਗ ਵਾਲੀ, (877) 737-7776 ਤੇ ਸੂਚਕ ਵੇਅੜੀ।
Language Access Services:

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

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

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

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

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

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

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

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

Urdu (اردو): اگر اس نسٹاراہ کے بارے میں آپ کا کوئی سوال ہے، آپ اور اپنے زبان میں مفت معلومات حاصل کر سکتے ہیں اور اس کے لئے (877) 737-7776 پر کال کریں.

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

Yiddish (אידיש): אין אני אינע ניטן טעומע דעם דואקעוםון, אינט אינא רענטן ני בקוצומעס דעם אינפראמסאציעאער אינא יישער שפעראַר בלען דער. (877) 737-7776

Yoruba (Yorùbá): Tí o bá ní éyíkéyá iberé nipa àkọṣéle yìí, o ní ètò látì gbà èràn wòò àtì iwínì à ni èdè rì fọ̀ò. Bá wa ọgbù́rú kan sọ́rù, pe (877) 737-7776.
Language Access Services:

It’s important we treat you fairly

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

- This glossary 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-insurance**

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance **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 co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

**Complications of Pregnancy**

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

**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.
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

<table>
<thead>
<tr>
<th>January 1st</th>
<th>December 31st</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning of Coverage Period</td>
<td>End of Coverage Period</td>
</tr>
</tbody>
</table>

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, 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