The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.healthnet.com or call 1-800-926-4921. 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 www.healthnet.com/calpers or you can call 1-800-926-4921 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$0.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>Yes. Medical: Individual $1,500 / Family $3,000. Pharmacy: Individual $6,400 / Family $12,800 Mail order $1,000.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have family members in this plan, the overall family out-of-pocket limit must be met. OptumRx serves CalPERS’ pharmacy benefit manager.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, copayments for supplemental benefits 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><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. For a list of preferred providers, see <a href="http://www.healthnet.com/calpers">www.healthnet.com/calpers</a> or call 1-800-926-4921.</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><strong>Do you need a referral to see a specialist?</strong></td>
<td>Yes. Requires written prior authorization.</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>SIMNSA Network (Mexico members)</th>
<th>Health Net Salud Network (California members)</th>
<th>SIMNSA Network (Self-referral for California members)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15/visit</td>
<td>$15/visit</td>
<td>$15/visit</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15/visit</td>
<td>$15/visit</td>
<td>$15/visit</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Requires referral.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$5 for drugs dispensed through SIMNSA/retail order</td>
<td>$5/30 day supply $10/90 day supply</td>
<td>$5 for drugs dispensed through SIMNSA/retail order</td>
<td>Health Net Salud Network- After second fill you will pay the appropriate mail service copay for maintenance medication. 90 day supplies allowed at a contracted OptumRx pharmacy or mailorder.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Not covered/ mail order</td>
<td>$20/30 day supply $40/90 day supply</td>
<td>$20/30 day supply $40/90 day supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$50/30 day supply $100/90 day supply</td>
<td>Not covered/ mail order</td>
<td>$50/30 day supply $100/90 day supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Not applicable</td>
<td>Specialty follows tier structure above</td>
<td>Not applicable</td>
<td>Health Net Salud Network- Certain Speciality Medications are available only through the OptumRx Specialty pharmacy and are limited up to a 30-day supply.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.healthnet.com/calpers](http://www.healthnet.com/calpers)
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</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>---------------none--------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$15/visit</td>
<td>$50/visit</td>
<td>$15/visit</td>
<td>Cost share waived if admitted as an inpatient.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>---------------none--------------</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15/visit</td>
<td>$15/visit</td>
<td>$15/visit</td>
<td>Cost share waived if admitted as an inpatient.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>---------------none--------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office-$15/visit- Other than office- No charge</td>
<td>Office- $15/visit-individual therapy session $7.50/visit- group therapy session Other than office- No charge</td>
<td>Office-$15/visit- Other than office- No charge</td>
<td>Prior authorization required except for office visits.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Cost sharing does not apply for preventive services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Coverage includes abortion services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Coverage includes abortion services. Requires prior authorization.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.healthnet.com/calpers](http://www.healthnet.com/calpers)
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</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td><strong>Home health care</strong></td>
<td>Not covered</td>
<td>No charge</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>$5/visit</td>
<td>$15/visit</td>
<td>$5/visit</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>$5/visit</td>
<td>$15/visit</td>
<td>$5/visit</td>
<td>Requires prior authorization. Covered when medically necessary.</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Requires prior authorization. Limited to 100 days per calendar year. Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Hospice care is covered in Mexico, but only when services are provided in an acute hospital setting. Requires prior authorization.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</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>Not covered</td>
<td>none</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Child & Adult)
- Glasses
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Out-of-network services
- Private-duty nursing
- Routine foot care
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at [www.healthnet.com/calpers](http://www.healthnet.com/calpers)
### Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>$15 per visit, 20 visits per calendar year (combined) through American Specialty Health Plan.</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td></td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>$15 per visit, 20 visits per calendar year (combined) through American Specialty Health Plan.</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>($1,000 max per member every 36 months)</td>
</tr>
<tr>
<td>Infertility treatment</td>
<td></td>
</tr>
<tr>
<td>Routine eye care (Adult)</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 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.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 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: Health Net’s Customer Contact Center at 1-800-522-0088, submit a grievance form through www.healthnet.com/calpers, or file your complaint in writing to, Health Net Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348. For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444 (EBSA (3272) or www.dol.gov/ebsa/healthreform. If you have a grievance against Health Net, you can also contact the California Department of Managed Health Care, at 1-800-HMO-2219 or www.hmohelp.ca.gov. For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444 (EBSA (3272) or www.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.

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com/calpers
Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-926-4921.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-926-4921.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-926-4921.
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ 1-800-926-4921.

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.

---

**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) copayment: $0
- Other copayment: $15

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

Total Example Cost: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$50</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Peg would pay is: $110

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

---

**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) copayment: $0
- Other copayment: $15

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: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Joe would pay is: $660

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

---

**Mia’s Simple Fracture**
(in-network emergency room visit and follow up care)

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

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: $2,500

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Mia would pay is: $200

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

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

Health Net:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
• Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net’s Customer Contact Center at 1-888-926-4921 (TTY: 711).

If you believe that Health Net has failed to provide these services or discriminated in another way, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net’s Customer Contact Center is available to help you. You can also file a grievance by mail:


If you are not satisfied with Health Net’s decision or it has been more than 30 days since you filed the complaint, you may submit a complaint form to the Department of Managed Health Care (DMHC).

The form is available at www.dmhc.ca.gov/FileaComplaint. 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, 1-800-368-1019 (TDD: 1-800-537-7697) if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or call 1-888-926-4921 (TTY: 711).

Arabic
خدمات اللغة مجانية يمكنك الحصول على مترجم مجاني. يمكنك الحصول على وثائق مترجمة لك للحصول على المساعدة. اتصل بنا على الرقم الموجود على بطاقة الهوية، أو اتصل على مركز الاتصال التجاري (TTY: 711) 1-888-926-4921.

Armenian
Անվճար լեզուային ծառայություններ. Համարակալքի համար, սակկվել եք դեմք նյարդի բանկային կարտի վրա բերված համարսայրի համար կամ, սպասարկած համարսայրի համար կարելի է կարհինանել 1-888-926-4921 (TTY: 711).

Chinese
免费语言服务。您可使用口译员。您可请人使用您的语言将文件内容读给您听，并请我们把您语言版本的部分文件寄给您。如需协助，请致电您会员卡上所列的电话号码与我们联络，或致电 1-888-926-4921（TTY: 711）。

Hindi
बनियां लागत की भाषा सेवाएं। आप एक द्वारा संस्कृति पर अधिक कर सकते हैं। आप को दस्तावेज पढ़ कर सुनाए जा सकते हैं। मुद्दत के लिए, आपके आईडी कार्ड पर दर्ज गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-888-926-4921 (TTY: 711)

Hmong

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号まで電話いただくか、1-888-926-4921（TTY: 711）。
Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el 1-888-926-4921 (TTY: 711).

Tagalog

Thai
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Vietnamese
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.

**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.

**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
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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.

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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.

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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.

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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.

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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)
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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

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

December 31st
End of Coverage Period

Jane pays 0%  Her plan pays 100%

Jane reaches her $5,000 out-of-pocket limit
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $200
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- **Her plan:** 0%

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Her plan doesn’t pay any of the costs.  
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- **Jane:** 20%  
- **Her plan:** 80%

Jane reaches her $1,500 deductible, **co-insurance begins**  
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**December 31st**  
*End of Coverage Period*

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- **Her plan:** 100%

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