### Important Questions

| What is the overall deductible? | $500/member or $1,000/family for In-Network Providers. $500/member or $1,000/family for Out-of-Network Providers. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |

| Are there services covered before you meet your deductible? | Yes. Preventive care, Primary Care visit, and Specialist visit for In-Network Providers. | 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 [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/). |

| Are there other deductibles for specific services? | Yes. $50/visit for Emergency room services (waived if admitted directly from ER). | 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. |

| What is the out-of-pocket limit for this plan? | $3,000/single or $6,000/family for In-Network Providers. No Out-of-Pocket limit when using Out-of-Network Providers. This plan has a separate Out of Pocket Maximum for Prescription Drugs $2,000/single or $4,000/family $1,000 Home delivery. | 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. |

| What is not included in the out-of-pocket limit? | Premiums, Balance-Billing charges, and Health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |

| Will you pay less if you use a network provider? | Yes, Prudent Buyer PPO. See [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers) or call (877) 737-7776 for a list of network providers. | 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. |
Do you need a **referral** to see a **specialist**?

No. You can see the specialist you choose without a referral.

---

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>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20/visit medical deductible does not apply</td>
<td>40% coinsurance</td>
<td>---------none---------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$35/visit medical deductible does not apply</td>
<td>40% coinsurance</td>
<td>---------none---------</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>---------none---------</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>---------none---------</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>---------none---------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$5/30 day supply $10/90 day supply</td>
<td>Not Covered 100% Out of Pocket</td>
<td>After second fill you will pay the appropriate mail service copay for maintenance medications. 90 day supplies (OptumRx Select90 Saver) allowed at Walgreens and Home Delivery program.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$20/30 day supply $40/90 day supply</td>
<td>Not Covered 100% Out of Pocket</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 100% Out of Pocket</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Specialty follows the tier structure above</td>
<td>Not Covered 100% Out of Pocket</td>
<td>Certain Specialty Medications are available only through BriovaRx Specialty Pharmacy limited to a 30-day supply.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee e.g. Ambulatory Surgery Center; ASC</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Services and supplies for the following outpatient surgeries are limited: Colonoscopy limited to $1,500 per procedure, Cataract surgery limited to $2,000 per procedure; Arthroscopy limited to $6,000 per procedure. Benefits limited to $350 for ASC per day for Non-PPO providers.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>---------none---------</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers).
<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>If you need immediate medical attention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$35/visit medical deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit $20/visit medical deductible does not apply Other Outpatient 20% coinsurance</td>
<td>40% coinsurance Other Outpatient 40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance first 10 days. 30% coinsurance the following 90 days</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at www.anthem.com/ca/calpers.
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>--------none--------</td>
</tr>
<tr>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>--------none--------</td>
</tr>
<tr>
<td>Dental check-up</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
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes.
- Dental routine care (adult)
- Personal development programs
- Weight loss programs
- Infertility treatment
- Private-duty nursing

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

- Acupuncture 20 visits/benefit period.
- Hearing aids $1,000 maximum every 36 months.
- Bariatric surgery
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Chiropractic care 20 visits/benefit period.

### 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, considered an Adverse Benefit Determination (ABD) you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Grievance and Appeals 1-877-737-7776 or Anthem Blue Cross Attention: Grievance and Appeals P.O. Box 60007 Los Angeles, CA 90060-0007

If Anthem Blue Cross upholds the ABD, that decision becomes a Final Adverse Benefit Determination (FABD) and you may request an independent External Review. If you are not satisfied with Anthem Blue Cross’ FABD, the independent External Review decision or you do not want to pursue the independent External Review Process, you may request an Administrative Review from CalPERS. The request must be mailed to: CalPERS Health Plan Administration Division/ Health Appeals Coordinator P.O. Box 1953 Sacramento, CA 95812-1953

### 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 plan or policy document at [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers).
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: $500
- Specialist copayment: $20
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

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>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$80</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,480</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>$60</strong></td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td><strong>$3,120</strong></td>
</tr>
</tbody>
</table>

### Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)
- The plan’s overall deductible: $500
- Specialist copayment: $20
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost:** $7,460

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$280</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,834</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>$21</strong></td>
</tr>
<tr>
<td>The total Joe would pay is</td>
<td><strong>$2,355</strong></td>
</tr>
</tbody>
</table>

### Mia’s Simple Fracture (in-network emergency room visit and follow up care)
- The plan’s overall deductible: $500
- Specialist copayment: $20
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost:** $2,010

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$326</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td><strong>$886</strong></td>
</tr>
</tbody>
</table>

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 gjithë tuaj. Për të kontaktuar me një përkthyes, telefononi (877) 737-7776

Amharic (አማርኛ): የት ልያቃ ይላማርኛውን ከተማ ከንጠቀም ይወጥም ለሁኔታ ከወቅም ለምሳሌ ከነጠቀም ያላለኝ ከስፍን ይናሉ። የሚያስችሉ ከተማ ከወቅም ከወቅም ያላለኝ ከተማአለፋለፈው። (877) 737-7776 የሚልፋለፈው።

Arabic: إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 776-737-7776(877).

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:

Bassa (Bàssò Wùdù): Ê dyi dyi-die-dë bë bëcé bá céè-dë nià ke dyi nì, ñ mè ni dyi-dëjëin-dë bë m ké gbo-kpá-kpá kë bò kpö dé m bídi-wùdùún bò pìdyi. Bë m ké wùdù-zëin-nyò dò gbo wùdù ke, dà (877) 737-7776.

Bengali (বাংলা): যদি এই নথিভুক্তের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও ভাষায় পাওয়ার অধিকার আপনার আছে। একজন পাতায়ির সাথে কথা বলার জন্য (877) 737-7776 বা ৭৩৭-৭৭৭৬

Burmese (မြန်မာ) : မြန်မာစာလုံးပေါင်းအဖြစ်သည် များပျော်ရွှင်ရှိနိမ့်တော်လှန်မှု့ကို ပြောင်းလဲနိုင်မှုကို အဘယ်မှ ပြောင်းလဲနိုင်ဖို့ ကျင်းပပြုရေးအတွက် အချိန်ကို များပျော်ရွှင်ရှိနိမ့်တော်လှန်ပါ (877) 737-7776 အချိန်ကို များပျော်ရွှင်ရှိနိမ့်တော်လှန်ပါ。

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

Dinka (Dink): Na nog tieeche nê ke de yà thorë, ke yin nog loq bé yi kuony ku wer akë bè geér yic yin ne thon du ke cin wèu tânë ke piny. Te kör yin ba jam wëne ran ye thok geriyic, 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 سند داردید، این حق را دارید که اطلاعات و کمک را بدون هیچ مزایایی به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، به شماره 776-737-7776 (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, appellez 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.

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Yoruba (Yorùbá): Ti o bá ní èyíkèyà ṣèrè nípa àkosilè yìí, o ni etọ látì ṣe irànwo àti ìwùnì ní èdè Yorùbá. Bá wa ogbọ̀fù kẹ̀n sòrò, pe (877) 737-7776.
Language Access Services:

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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 cesarean 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.
Jane’s Plan Deductible: $1,500    Co-insurance: 20%    Out-of-Pocket Limit: $5,000

**How You and Your Insurer Share Costs - Example**

**Jane has 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