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 (877) 737-7776 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>$1,000/Individual or $2,000/Family for all Providers. 5 Credits* available to reduce deductible to: $500/Individual or $1,000/Family for all Providers (Credits * listed on page 4).</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Prescription Drugs, Preventive care, Primary Care visit, and Specialist visit for In-Network Providers.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes. $50/visit for Emergency room services (waived if admitted directly from ER).</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$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.</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><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>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><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes, Prudent Buyer PPO. See <a href="http://www.anthem.com/ca/calpers">www.anthem.com/ca/calpers</a> or call (877) 737-7776 for a list of</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 covers.</td>
</tr>
</tbody>
</table>

CA/L/A/PERSSelectBasicPPOPlanforcalpers-PPO/NA/PVF0H/NA/01-19
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>$10 visit if enrolled with a personal doctor deductible does not apply</td>
<td>40% coinsurance</td>
<td>$35 visit if not enrolled with a personal doctor/PCP.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$35/visit 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>Coinsurance waived if enrolled with a personal doctor/PCP.</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>Certain Specialty Medications are available only through BriovaRx Specialty Pharmacy and are limited up to a 30-day supply.</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></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>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at 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>Physician/surgeon fees</td>
<td>In-Network Provider (You will pay the least) 20% coinsurance</td>
<td>If admitted directly to hospital $50 ER deductible waived.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Provider (You will pay the most) 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>In-Network Provider (You will pay the least) 20% coinsurance</td>
<td>Hip and Knee joint replacement surgery will be limited to $30,000 per procedure. A subset of participating hospitals meets this maximum benefit coverage. Pre-authorization required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Provider (You will pay the most) 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>In-Network Provider (You will pay the least) 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Provider (You will pay the most) 40% coinsurance</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 $10/visit if PCP enrolled deductible does not apply Other Outpatient 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Provider (You will pay the most) 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>In-Network Provider (You will pay the least) 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Out-of-Network Provider (You will pay the most) 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>In-Network Provider (You will pay the least) 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>In-Network Provider (You will pay the least) 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Out-of-Network Provider (You will pay the most) 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>In-Network Provider (You will pay the least) 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Provider (You will pay the most) 40% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at 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></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>20% coinsurance first 10 days 30% coinsurance following 90 days</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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 routine care (adult)
- Personal development programs
- Weight loss programs
- Long-term care
- Infertility treatment
- Private-duty nursing
- Routine foot care unless you have been diagnosed with diabetes.
- Bariatric surgery
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Acupuncture 20 visits/benefit period.
- Hearing aids $1,000 maximum every 36 months.
- Acupuncture 20 visits/benefit period.
- Chiropractic care 20 visits/benefit period.
- Bariatric surgery
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Credits * 1. Biometric Screening
- Credits * 2. Condition Care
- Credits * 4. Second Opinion
- Credits * 5. Smoking Cessation
- Credits * 3. Flu Shot
- Credits * 4. Second Opinion
- Credits * 5. Smoking Cessation

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.

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

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>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>$20</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</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)

Total Example Cost $12,840

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>Deductibles</td>
<td>Deductibles</td>
</tr>
<tr>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>Copayments</td>
<td>Copayments</td>
</tr>
<tr>
<td>$80</td>
<td>$1,200</td>
<td>$326</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Coinsurance</td>
<td>Coinsurance</td>
</tr>
<tr>
<td>$2,480</td>
<td>$624</td>
<td>$326</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>What isn’t covered</td>
<td>What isn’t covered</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>Limits or exclusions</td>
<td>Limits or exclusions</td>
</tr>
<tr>
<td>$60</td>
<td>$31</td>
<td>$0</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>The total Peg would pay is</td>
<td>The total Mia would pay is</td>
</tr>
<tr>
<td>$3,120</td>
<td>$3,120</td>
<td>$886</td>
</tr>
</tbody>
</table>

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>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$624</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$31</td>
</tr>
<tr>
<td>The total Joe would pay is</td>
<td>$2,355</td>
</tr>
</tbody>
</table>

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>Cost Sharing</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>What isn’t covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$31</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td>$886</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 gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (877) 737-7776

Amharic (አማርኛ): Nǐt እስከ እያለ ከማንኛውም እንደ ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛውም ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማንኛው穆 ከማን荑ው穆 ከማን荑=news search service=

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

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 (Ɓàsɔ Wùɖù): M dyi dyi-die-ɗè bë béćé bá ceè-dë nià ke dyi ni, o mò ni dyi-dëćèîn-ɗè bë m ké gbo-ɗpá-ɗpá kë bò kpö dë m bidi-wùɖù ŋó pìdyi. Bë m ké wùɖù-ziin-nyo dò gbo wùɖù ke, dà (877) 737-7776.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে তা হলে আপনার ভাষায় সাহায্য পাওয়ার ও ভাষা পাওয়ার অধিকার আপনার আছে। একজন পরামর্শকের সাথে কথা বলার জন্য (877) 737-7776 -তে কল করুন।

Burmese (မြန်မာစာ): ရှိသော မြန်မာစားသော မြန်မာစာမျက်နှာစွမ်းအင်းများအတွက် မြန်မာစားသော သင်္ချာစာအုပ်များကို အကြံပြုပါ။ အကြံပြုသော မြန်မာစားသော မြန်မာစာမျက်နှာစွမ်းအင်းများကို အကြံပြုပါ။ (877) 737-7776

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (877) 737-7776。

Dinka (Dinka): Na ngon thiéèè nè ke de yà thorë, ke yìn ngon loŋ bë yì kuony ku wer alëu bë geër yic yìn ne thon du ke cin wëu tääë ke piny. Te kor yin ba jäm wênë ran ye thok geysièc, ke yìn 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 هزینه‌ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، به شماره 737-7776 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 διερμηνεύτη, τηλεφωνήστε στο (877) 737-7776.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રশ્નો લાગો તો, ડૉક્યન્ટ્સ જાહેર વગર આપની ભાષામાં મદદ અને માહત્ય મળવાનું તમારું અધિકાર છે. દુભાજીયા સાથે વાત કહી શક્ય છે, 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 दस्तावेज के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाजीये से बात करने के लिए, कॉल करें (877) 737-7776.

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsì ntsìg 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 ị nwere ajụ ọ bụla gbasara akwụkwọ a, ị nwere ikike īnweta enyemaka na ozi n'asụsụ gị na akwụgbọ ụgwọ ọ bụla. Ka gị na ọkowa okwu kwu okwu, kpọọ (877) 737-7776.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggcep 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 お電話ください。
Language Access Services:

Khmer (ខ្មែរ): ប្រិយប្រែសម្រាប់នៃការអោយជោគជ័យ: មានសុវត្ថិភាពចូលរួមប្រការការប្រការប្រការអាំពីការសិក្សារបស់អ្នក។ ចូរទាញយោង (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): ທ່ານ/ທ່າتنມີຄ່າງຄ່າງໃໝ່ໃນການການການການ, ຂ່າວມິດຫຼາຍໃຫ້ຂ້າງຂໍ້ະກວດຂຶ້ນຂຶ້ນເອີ້ມ. ເຊີ່ງໃຊ້ການທ້າຍບາງບາງເຂດ, ວິທີຢູດ (877) 737-7776.

Navajo (Diné): Dií naáltsoos biká’ígii lahhó bina’idilkidgo ná bohonnéedzā dóó bee ahó’ít’í t’áá ni nízaad k’eéjí bee nil hodoonih táadoo bááh ílinígóó. Ata’halné’ígii la’ bich’í’ hadeesdzih nínizingo kojí hodiílnih (877) 737-7776.

Nepali (नेपाली): यदि आप कागजातवार्ग संताप से हैं, वह स्वीकार में हैं, आपने भाषामा निश्चित सहयोग तथा जानकारी प्राप्त करने का अधिकार है। आपको कल गार्डियान (877) 737-7776 की संख्या से जवाब देनी है।

Oromo (Oromifaa): Sanadi kanaa wajiiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuuf fi odeefanoo afaan kettii 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): ਨੰ ਤੁਰੈ ਦੀ ਟੰਟ ਕਲਮਨਟ ਚਰਜ਼ ਕੇਲੀ ਤਕਸਨ ਟੂਟੇ ਤਕਨਾਂ ਤੁਰੈ ਕੇਲ ਸਵੀਅਜ਼ ਦਿੱਕ ਦੀਸ ਕੱਟ ਨਹੀਂ ਕੇਲਾ ਅਤੇ ਨਾਡਵਾਲੀ ਪ੍ਰਦੱਸ਼ਣ ਵਲ ਦੀ ਅਧਿਕਾਰ ਆਉਂਦੀ ਹੈ। ਦਿੱਕ ਟੂਟੇ ਤਕਨ ਹੋ ਵਲ ਹੋ ਸੀ, (877) 737-7776 ਤੇ ਆਪਣਾ ਕਲਮਾ।
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 (Samoa):** 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 totogi. 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 ท่านมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใชจ่าย โดยโทร (877) 737-7776 เพื่อพูดคุยกับล่าม.

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

** Urdu (اردو):** اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے یا آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنا چاہتے ہیں، آپ کے لئے ان کے ساتھ مزید سوال کریں یا (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 thống dịch viên, hãy gọi (877) 737-7776.

** Yiddish (אידיש):** איך או זיך יידישן ימען דעך דוקומנטען, זא יואיר די רעכן זא בקואמען דוקומנטען זיך איזער שופארך איזער ש pesquisa או זיך. (877) 737-7776.

** Yoruba (Yorùbá):** Tí o bá ni èyíkéyí èbèrè nipa àkọsìlè yìí, o ni ètọ̀ láti gba íranwọ̀ àti ìwùnì ní èdè re ìfọ̀rè. Bá wá ógbùfù kàn sòjì, 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. (See page 4 for a detailed example.)

### 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

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

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

December 31st
End of Coverage Period