



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.combinedbenefitsadministrators.com](http://www.combinedbenefitsadministrators.com) or by calling 800.709.4734.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<p><b>In-Network:</b> Individual: <b>\$0</b> Family: <b>\$0</b> Out-of-network applies to in-network amount and vice-versa</p> <p><b>Out-of-Network:</b> Individual: <b>\$400</b> Family: <b>\$800</b> Out-of-network applies to in-network amount and vice-versa</p> <p>Does not apply to copayments, amounts in excess of UCR, services not covered, preventive care, office visits, emergency care</p>	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. The <u>deductible</u> starts over July 1 <sup>st</sup> of every Plan Year. See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	<p><b>In-Network:</b> Individual: <b>n/a</b> Family: <b>n/a</b></p> <p><b>Out-of-Network:</b> Individual: <b>\$2,000</b> Family: <b>\$4,000</b></p>	The <u>out-of-pocket</u> limit is the most you could pay during a coverage period (usually one year) for your share of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Amounts in excess of UCR, expenses not covered by the plan	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	Yes. Annual Maximum Amount <b>\$2,000,000</b> . Lifetime Maximum Amount is unlimited.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. Networks by Design (NBD) is the preferred provider network utilized by the City of Turlock. See <a href="http://www.netbyd.com">www.netbyd.com</a> for a list of participating providers.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, preferred, or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .

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# CITY OF TURLOCK: SELF-FUNDED HEALTH PLAN

Coverage Period: 07/01/2015 - 06/30/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: All Coverage Types | Plan Type: EPO

Important Questions	Answers	Why this Matters:
Do I need a referral to see a <u>specialist</u> ?	No. Self-referral to a specialist is acceptable.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes. See limitations and exclusions section.	Some of the services this plan doesn't cover are listed below (see Excluded Services & Other Covered Services). See your plan document/SPD for additional information about <u>excluded services</u> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 copayment/visit	40% coinsurance	Deductible does not apply in-network.
	Specialist visit	\$20 copayment/visit	40% coinsurance	Deductible does not apply in-network.
	Allergy injections at a physician's office	\$5 copayment/visit	40% coinsurance	Deductible does not apply in-network. This lower copay applies when no physician visit is required.
	Preventive care/screening/immunization	\$20 copayment	Not Covered	Deductible does not apply in-network. Covered as an in-network benefit only. Well baby care only covered for the first 2 years of life, in network only.
If you have a test	Diagnostic test (x-ray, blood work)	\$15 copayment	40% coinsurance	Deductible does not apply in-network.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	\$15 copayment	40% coinsurance	Precertification required. Service may not be covered if not obtained. Must be performed at approved facility.
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.caremark.com">www.caremark.com</a></p>	Generic drugs	\$10 copayment / prescription (retail and mail order)	\$10 copayment + 25% coinsurance	Covers up to a 34-day supply (retail prescriptions). Covers up to a 120-day supply (mail order prescriptions).
	Preferred brand drugs	\$25 copayment / prescription (retail and mail order)	\$25 copayment + 25% coinsurance	Covers up to a 34-day supply (retail prescriptions). Covers up to a 120-day supply (mail order prescriptions). Doctor must write dispense as written for a multi-source brand name prescription drug to be covered. If not, the member would pay the brand copay plus the difference between the generic and preferred brand name drug cost.
	Non-preferred brand drugs	\$40 copayment / prescription (retail and mail order)	\$40 copayment + 25% coinsurance	Covers up to a 34-day supply (retail prescriptions). Covers up to a 120-day supply (mail order prescriptions). Doctor must write dispense as written for a multi-source brand name prescription drug to be covered. If not, the member would pay the brand copay plus the difference between the generic and preferred brand name drug cost.
	Specialty drugs	\$40 copayment / prescription (retail and mail order)	Not covered	Drugs may only be purchased through the CVS Health specialty pharmacy program.

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# CITY OF TURLOCK: SELF-FUNDED HEALTH PLAN

Coverage Period: 07/01/2015 - 06/30/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: All Coverage Types | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 per admit to an outpatient hospital facility \$200 per admit to an ambulatory surgery center	40% coinsurance	Deductible does not apply in-network. Precertification required. Payment for the service may not be covered if precertification is not obtained.
	Physician/surgeon fees	No Charge	40% coinsurance	Deductible does not apply in-network.
If you need immediate medical attention	Emergency room services	\$150 copayment	\$150 copayment	Deductible does not apply both in-network and out-of-network. Copayment is waived if admitted to the hospital. If admitted, the hospital copay will apply.
	Emergency medical transportation	First \$50 per trip is covered at 100%; + 30% coinsurance	First \$50 per trip is covered at 100%; + 30% coinsurance	Includes emergency air transportation. Deductible does not apply in-network. Paid at in-network level if true emergency.
	Urgent care	\$25 copayment	40% coinsurance	Deductible does not apply in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 per admit	40% coinsurance	Deductible does not apply in-network. Precertification required. Payment for the service may not be covered if precertification not obtained. In-network hospital copayments will be waived after a Covered Person has paid \$1,200 out-of-pocket for such copayments in a Plan Year.
	Physician/surgeon fee	No Charge	40% coinsurance	Deductible does not apply in-network.

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Coverage Period: 07/01/2015 - 06/30/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: All Coverage Types | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$20 copayment	40% coinsurance	Deductible does not apply in-network.
	Mental/Behavioral health inpatient services	\$500 per admit	40% coinsurance	Deductible does not apply in-network. Precertification required. Payment for the service may not be covered if precertification not obtained.
	Substance use disorder outpatient services	\$20 copayment	40% coinsurance	Deductible does not apply in-network.
	Substance use disorder inpatient services	\$500 per admit	40% coinsurance	Deductible does not apply in-network. Precertification required. Payment for the service may not be covered if precertification not obtained.
<b>If you are pregnant</b>	Prenatal and postnatal care	As any other illness	40% coinsurance	Copays apply just as any other service. \$20 per office visit, \$15 per lab test, or \$500 per hospital admission.
	Delivery and all inpatient services	\$500 per admit	40% coinsurance	Deductible does not apply in-network. Precertification required for extended stay. Payment for the service may not be covered if precertification not obtained. Copays apply just as any other service.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	40% coinsurance	Deductible does not apply in-network. Precertification required. Payment for the service may not be covered if precertification not obtained. Limited to 100 visits per year. Each visit of 4 hours or less will count as 1 visit.
	Rehabilitation services	No Charge	40% coinsurance	Check with plan for limitations that may apply based on type of therapy. Therapies included: cardiac rehabilitation, occupational, physical, pulmonary/respiratory, speech. Deductible does not apply in-network. Precertification required. Payment for the service may not be covered if precertification not obtained.
	Habilitation services	\$20 copayment	40% coinsurance	Deductible does not apply in-network. Precertification required. Payment for the service may not be covered if precertification not obtained.
	Skilled nursing care	No Charge	40% coinsurance	Deductible does not apply in-network. Precertification required. Payment for the service may not be covered if precertification not obtained. Limited to 120 days per year.
	Durable medical equipment	No Charge	40% coinsurance	Durable medical equipment includes medical supplies. Deductible does not apply in-network.

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Coverage Period: 07/01/2015 - 06/30/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: All Coverage Types | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Hospice service	No Charge	40% coinsurance	Deductible does not apply in-network. Precertification required. Payment for the service may not be covered if precertification not obtained. Bereavement counseling covered to a maximum of \$50 per session.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Covered through Vision Service Plan.
	Glasses	Not Covered	Not Covered	Covered through Vision Service Plan.
	Dental check-up	Not Covered	Not Covered	Covered through Delta Dental of CA.

## Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult) – Covered through Delta Dental of CA</li> <li>• Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Long-term Care</li> <li>• Private Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Eye Care (Adult) – Covered through Vision Service Plan</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul>

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>• Acupuncture (for rehabilitation purposes)</li> <li>• Bariatric Surgery (at select providers)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Most Coverage Provided Outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Non-Emergency Care while Traveling outside the U.S.</li> </ul>

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## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **800.709.4734**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact a plan representative at: **800.709.4734** or visit us at [www.combinedbenefitsadministrators.com](http://www.combinedbenefitsadministrators.com). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program may be available in your state to help you with your appeal. Visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Under "Internal Claims and Appeals and External Review", select *Consumer Assistance Programs* for contact information of those states currently offering programs to assist consumers in filing an appeal.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800.709.4734.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800.709.4734.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800.709.4734.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800.709.4734.

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

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,550
- Patient pays \$990

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$0
Copays	\$840
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$990</b>

These amounts assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not notified the plan, your costs may be higher. For more information, contact 800.709.4734 or visit us at [www.combinedbenefitsadministrators.com](http://www.combinedbenefitsadministrators.com).

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,530
- Patient pays \$870

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$0
Copays	\$790
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$870</b>

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 800.709.4734 or visit us at [www.combinedbenefitsadministrators.com](http://www.combinedbenefitsadministrators.com).

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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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

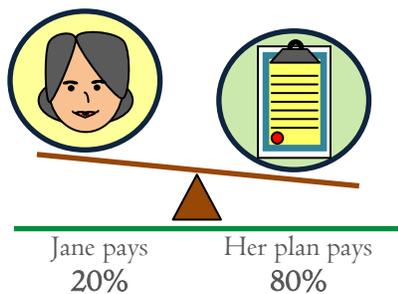
A request for your health insurer or **plan** to review a decision or a **grievance** again.

## 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.



(See page 4 for a detailed example.)

## Complications of Pregnancy

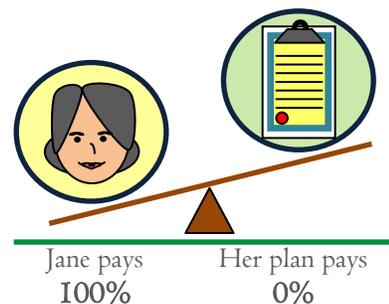
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

## Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

## Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

## 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

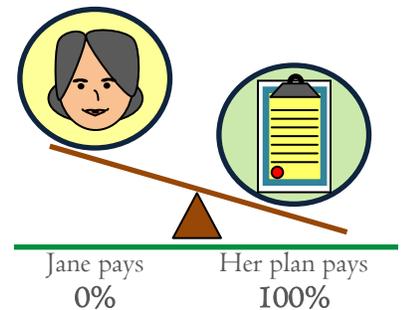
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

## 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

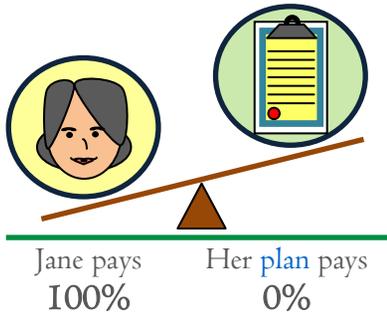
Jane's Plan Deductible: \$1,500

Co-insurance: 20%

Out-of-Pocket Limit: \$5,000

January 1<sup>st</sup>  
Beginning of Coverage  
Period

December 31<sup>st</sup>  
End of Coverage Period



## Jane hasn't reached her \$1,500 deductible yet

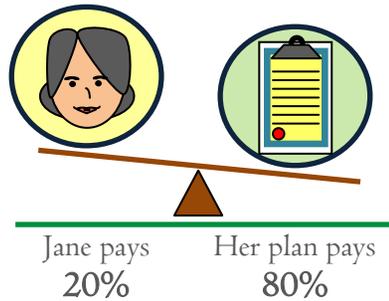
Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0

more costs



## Jane reaches her \$1,500 deductible, co-insurance begins

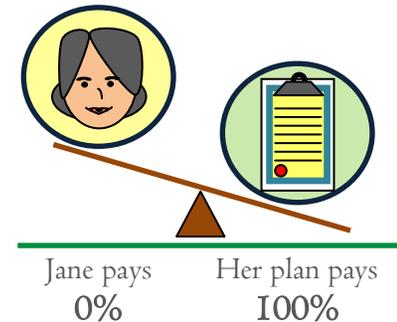
Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: \$75

Jane pays: 20% of \$75 = \$15

Her plan pays: 80% of \$75 = \$60

more costs



## Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$200

Jane pays: \$0

Her plan pays: \$200