The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/LGBooklet or call 1-800-ASK-BLUE (TTY:711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-ASK-BLUE (TTY:711) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | For Tier 1 and Tier 2 In-Network providers $0/person; $0/family. For Out-of-Network providers $500/person; $1,000/family. | 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 services, Specialist services and Emergency room services are covered before you meet your deductible. | 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/. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | For In-network Tier 1 providers $1,000/person; $2,000/family. For In-network Tier 2 providers $2,000/person; $4,000/family. For Out-of-Network providers $3,000/person; $6,000/family. | 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. See www.ibx.com/find_a_provider or call 1-800-ASK-BLUE (TTY:711) for a list of network providers. | The plan uses a provider network. You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-network Tier 1 (You will pay the least) | In-network Tier 2 | Out of Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No charge | $15/Visit | 20% coinsurance | None |
| | Specialist visit | $10/Visit | $25/Visit | 20% coinsurance | None |
| | Preventive care/screening/immunization | No charge | No charge | 20% coinsurance; Deductible does not apply. | Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | No charge | 20% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | No charge | No charge | 20% coinsurance | Precertification required for certain services; 20% reduction in benefits for failure to precert out-of-network care or BlueCard services. |
| If you need drugs to treat your illness or condition<br><br>More information about prescription drug coverage is available at https://www.optumrx.com/public/landing | Generic Drugs | **Retail**: $10 copayment<br>**Mail**: $20 copayment | | | Covers up to a 30-day supply (retail) and a 90-day supply (mail order). For a list of participating retail pharmacies, go to www.optumrx.com or call 1-800-356-3477. Contact OptumRx if you intend to use a non-participating pharmacy.<br><br>**Note**: Step Therapy and prior authorization (PA) may be required. |
| | Preferred Brand | **Retail**: $30 copayment<br>**Mail**: $60 copayment | | | |
| | Non Preferred Drugs | **Retail**: $50 copayment<br>**Mail**: $100 copayment | | | |
| | Specialty Drugs | No charge | No charge | 20% coinsurance | This cost share amount is for specialty injectable or infusion therapy drugs covered by the medical benefit. These drugs are typically administered by a health care professional in a home, office or outpatient facility. Prior authorization required. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | No charge | 20% coinsurance | Precertification required; 20% reduction in benefits for failure to pre-authorize out-of-network outpatient services or treatments. |
| | Physician/surgeon fees | No charge | No charge | 20% coinsurance | |

*For more information about limitations and exceptions, see plan or policy document at www.ibx.com/LGBooklet.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-network Tier 1 (You will pay the least) | In-network Tier 2 | Out of Network Provider (You will pay the most) | |
| If you need immediate medical attention | Emergency room care | $100/Visit | $100/Visit | Covered at in-network level | None |
| | Emergency medical transportation | No charge | No charge | Covered at in-network level | |
| | Urgent care | No charge | $35/Visit | 20% coinsurance | Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | No charge | 20% coinsurance | Precertification required; $1,000 member penalty for failure to pre-authorize inpatient services or out-of-network treatment. |
| | Physician/surgeon fees | No charge | No charge | 20% coinsurance | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Not available | $25/Visit | 20% coinsurance | Precertification required; 20% reduction in benefits for failure to pre-authorize out-of-network outpatient services or treatments. |
| | Inpatient services | Not available | No charge | 20% coinsurance | Precertification required; $1,000 member penalty for failure to pre-authorize inpatient services or out-of-network care. |
| If you are pregnant | Office visits | $10 copayment – first visit only | $15 copayment – first visit only | 20% coinsurance | Office visit copayment applies to the first OB visit only. Depending on the type of services, additional copayments or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g.; ultrasound). Pre-notification requested for maternity care. |
| | Childbirth / delivery professional services | No charge | No charge | 20% coinsurance | |
| | Childbirth / delivery facility services | No charge | No charge | 20% coinsurance | Office visit copayment applies to the first OB visit only. Depending on the type of services, additional copayments or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC. Pre-notification requested for maternity care. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-network Tier 1 (You will pay the least) | In-network Tier 2 | Out of Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | No charge | No charge | 20% coinsurance | Precertification required; 20% reduction in benefits for failure to pre-authorize out-of-network outpatient services or treatments. |
| | Rehabilitation services | No charge | $25/Visit | 20% coinsurance | Precertification required; 20% reduction in benefits for failure to pre-authorize services provided by a BlueCard PPO Provider or out-of-network outpatient services or treatments. |
| | Habilitation services | No charge | $25/Visit | 20% coinsurance | Precertification required; 20% reduction in benefits for failure to pre-authorize services provided by a BlueCard PPO Provider or out-of-network outpatient services or treatments. |
| | Skilled nursing care | Not available | No charge | 20% coinsurance | Precertification required; $1,000 member penalty for failure to pre-authorize inpatient services or out-of-network care. Maximum 120 visits/Calendar Year. |
| | Durable medical equipment | Not available | No charge | 20% coinsurance | Precertification required;20% reduction in benefits for failure to pre-authorize out-of-network outpatient services or treatments. |
| | Hospice services | No charge | No charge | 20% coinsurance | Precertification required; $1,000 member penalty for failure to pre-authorize inpatient services or out-of-network care. |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | Not covered | None |

## Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Cosmetic surgery | • Dental care | • Hearing aids |
| • Infertility treatment | • Long-term care | • Routine eye care |
| • Routine foot care | • Weight loss programs | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture | • Bariatric surgery | • Chiropractic care |
| • Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com | • Private-duty nursing (outpatient only) | |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. To contact the plan call 1-800-275-2583 (TTY: 711). The contact information for these agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; For a non-federal governmental group health plan, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for a non-federal governmental group health plan or a church plan that Is a group health plan, contact the plan at 1-800-275-2583 (TTY:711).

**Does this plan provide Minimum Essential Coverage?** Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet 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.

**Language Access Services:**
[Spanish (Español): Para obtener asistencia en Español, llame al [1-800-ASK-BLUE].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-800-ASK-BLUE].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[1-800-ASK-BLUE].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-800-ASK-BLUE].]

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

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## About these Coverage Examples:



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

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $10 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

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 | $12,700 |
|---|---|
| In this example, Peg would pay: | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $20 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $80 |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $10 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

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 | $5,600 |
|---|---|
| In this example, Joe would pay: | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| The total Joe would pay is | $820 |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $10 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

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 | $2,800 |
|---|---|
| In this example, Mia would pay: | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $100 |

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

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

# Glossary of Health Coverage and Medical Terms

- This glossary defines 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 or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any 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.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

## Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

## Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

## Balance Billing

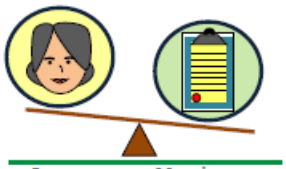
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

## Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

## Coinsurance

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




(See page 6 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 generally aren't complications of pregnancy.

## Copayment

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.

## Cost Sharing

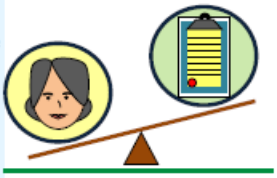
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

## Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

## Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (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.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

## Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

## Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

## Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

## Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

## Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

## Excluded Services

Health care services that your plan doesn't pay for or cover.

## Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

## 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 a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

## Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

## 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. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

## Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

### Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

### In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

### In-network Copayment
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 copayments usually are less than out-of-network copayments.

### Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

### Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

### Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

### Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

### Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

### Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

### Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

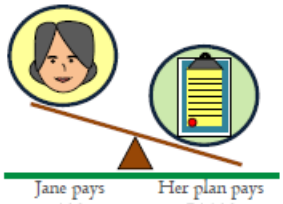
### Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

### Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

### Out-of-network Copayment
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 copayments usually are more than in-network copayments.

### Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out-of-network provider".

### Out-of-pocket Limit
The most you ***could*** pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.



(See page 6 for a detailed example.)

### Physician Services
Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

### Plan
Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

### Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) 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.

### 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.

### Premium Tax Credits
Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

### Prescription Drug Coverage
Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

### Prescription Drugs
Drugs and medications that by law require a prescription.

### Preventive Care (Preventive Service)
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

### Primary Care Physician
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

### Primary Care Provider
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

### Provider
An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be 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.

### Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

### 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.

### Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

### Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

### Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

### Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

### 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.

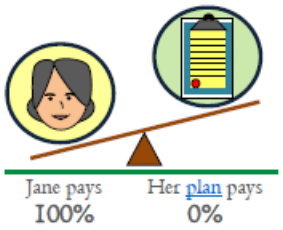
### Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

# How You and Your Insurer Share Costs - Example

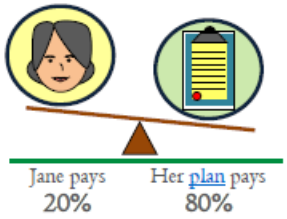
**Jane's Plan Deductible:** $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

*January 1st*
*Beginning of Coverage Period*

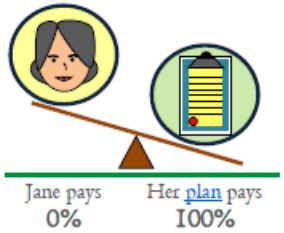
*December 31st*
*End of Coverage Period*




more costs




more costs




**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, coinsurance begins**
Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.
**Office visit costs:** $125
**Jane pays:** 20% of $125 = $25
**Her plan pays:** 80% of $125 = $100

**Jane reaches her $5,000 out-of-pocket limit**
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
**Office visit costs:** $125
**Jane pays:** $0
**Her plan pays:** $125

**Language Assistance Services**

**Spanish:** ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

**Chinese:** 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

**Korean:** 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

**Portuguese:** ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

**Gujarati:** સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

**Vietnamese:** LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

**Russian:** ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

**Polish** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

**Italian:** ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

**Arabic:**
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

**French Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

**Pennsylvania Dutch:** BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

**Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

**Japanese:** 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

**Persian (Farsi):**
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

**Navajo:** Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih koji' 1-800-275-2583.

**Urdu:**
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

**Mon-Khmer, Cambodian:** សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

## Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

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

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.