



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.healthnet.com](http://www.healthnet.com) or call 1-800-926-4921. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or [www.healthnet.com/calpers](http://www.healthnet.com/calpers) or you can call 1-800-926-4921 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Yes. Medical: Individual \$1,500 / Family \$3,000. Pharmacy: Individual \$6,400 / Family \$12,800 Mail order \$1,000.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met. OptumRx serves CalPERS' pharmacy benefit manager.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">copayments</a> for supplemental benefits and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of preferred providers, see <a href="http://www.healthnet.com/calpers">www.healthnet.com/calpers</a> or call 1-800-926-4921.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes. Requires written prior authorization.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



All [copayment](#) and [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
		SIMNSA Network (Mexico members)	Health Net Salud Network (California members)	SIMNSA Network (Self-referral for California members)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15/visit	\$15/visit	\$15/visit	—————none—————
	<a href="#">Specialist</a> visit	\$15/visit	\$15/visit	\$15/visit	Requires prior authorization.
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	No charge	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	No charge	No charge	Requires referral.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	No charge	Requires prior authorization.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com/calpers">www.optumrx.com/calpers</a>	Generic drugs	\$5 for drugs dispensed through SIMNSA/retail order Not covered/ mail order	\$5/30 day supply \$10/90 day supply	\$5 for drugs dispensed through SIMNSA/retail order Not covered/ mail order	Health Net Salud Network- After second fill you will pay the appropriate mail service copay for maintenance medication. 90 day supplies allowed at a contracted OptumRx pharmacy or mailorder.
	Preferred brand drugs		\$20/30 day supply \$40/90 day supply		
	Non-preferred brand drugs		\$50/30 day supply \$100/90 day supply		
	<a href="#">Specialty drugs</a>	Not applicable	Specialty follows tier structure above	Not applicable	Health Net Salud Network- Certain Speciality Medications are available only through the OptumRx Specialty pharmacy and are limited up to a 30-day supply.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SIMNSA Network (Mexico members)	Health Net Salud Network (California members)	SIMNSA Network (Self-referral for California members)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	No charge	Requires prior authorization.
	Physician/surgeon fees	No charge	No charge	No charge	—————none—————
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$15/visit	\$50/visit	\$15/visit	Cost share waived if admitted as an inpatient.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	No charge	—————none—————
	<a href="#">Urgent care</a>	\$15/visit	\$15/visit	\$15/visit	Cost share waived if admitted as an inpatient.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	No charge	Requires prior authorization.
	Physician/surgeon fees	No charge	No charge	No charge	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office-\$15/visit Other than office- No charge	Office- \$15/visit- individual therapy session \$7.50/visit- group therapy session Other than office- No charge	Office-\$15/visit Other than office- No charge	Prior authorization required except for office visits.
	Inpatient services	No charge	No charge	No charge	Requires prior authorization.
If you are pregnant	Office visits	No charge	No charge	No charge	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	No charge	No charge	Coverage includes abortion services.
	Childbirth/delivery facility services	No charge	No charge	No charge	Coverage includes abortion services. Requires prior authorization.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SIMNSA Network (Mexico members)	Health Net Salud Network (California members)	SIMNSA Network (Self-referral for California members)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Not covered	No charge	Not covered	Requires prior authorization.
	<a href="#">Rehabilitation services</a>	\$5/visit	\$15/visit	\$5/visit	Requires prior authorization.
	<a href="#">Habilitation services</a>	\$5/visit	\$15/visit	\$5/visit	Requires prior authorization. Covered when medically necessary.
	<a href="#">Skilled nursing care</a>	No charge	No charge	No charge	Limited to 100 days per calendar year. Requires prior authorization.
	<a href="#">Durable medical equipment</a>	No charge	No charge	No charge	Requires prior authorization.
	<a href="#">Hospice services</a>	No charge	No charge	No charge	Hospice care is covered in Mexico, but only when services are provided in an acute hospital setting. Requires prior authorization.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	—————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](#).)

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Child &amp; Adult)</li> <li>• Glasses</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Out-of-network services</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|--|---|---|

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

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

- Acupuncture– \$15 per visit, 20 visits per calendar year (combined) through American Specialty Health Plan.
- Bariatric surgery
- Chiropractic care – \$15 per visit, 20 visits per calendar year (combined) through American Specialty Health Plan.
- Hearing aids (\$1,000 max per member every 36 months)
- Infertility treatment
- Routine eye care (Adult)

### Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

### Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Health Net's Customer Contact Center at 1-800-522-0088, submit a grievance form through [www.healthnet.com/calpers](http://www.healthnet.com/calpers), or file your complaint in writing to, Health Net Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348. For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444 (EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). If you have a grievance against Health Net, you can also contact the California Department of Managed Health Care, at 1-800-HMO-2219 or [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov). For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444 (EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-926-4921.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-926-4921.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-926-4921.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-926-4921.

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*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$15

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

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$50
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$110</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$15

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

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$660</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$15

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

<b>Total Example Cost</b>	<b>\$2,500</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$200</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

# Nondiscrimination Notice

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

Health Net:

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

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

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

Health Net, PO Box 10348, Van Nuys, California 91410-0348, by fax: 1-877-831-6019, or online: [healthnet.com](http://healthnet.com).

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

The form is available at [www.dmhc.ca.gov/FileaComplaint](http://www.dmhc.ca.gov/FileaComplaint). You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697) if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



## English

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

## Arabic

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

## Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-888-926-4921 (TTY: 711).

## Chinese

免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 1-888-926-4921 (TTY: 711)。

## Hindi

बनाi लागत की भाषा सेवाएँ। आप एक दुभाषयिा प्राप्त कर सकते हैं। आपको दस्तावेज पढ कर सुनाए जा सकते हैं। मदद के लएि, आपके आईडी कार्ड पर दएि गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-888-926-4921 (TTY: 711)।

## Hmong

Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Xav tau kev pab, hu peb tau rau tus xov tooj ntawm koj daim npav los yog hu 1-888-926-4921 (TTY: 711).

## Japanese

無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、1-888-926-4921、(TTY: 711)。

**Khmer**

សេវាកម្មដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូម ទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្ម នៃក្រុមហ៊ុន 1-888-926-4921 (TTY: 711)។

**Korean**

무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 귀하가 구사하는 언어로 문서의 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나 1-888-926-4921 (TTY: 711).

**Navajo**

Saad Bee Áká E'eyeed T'áá Jíik'e. Ata' halne'ígíí hóló. T'áá hó hazaad k'ehjí naaltsoos hach'í' wóltah. Shíká a'doowoł nínízingo naaltsoos bee néího'dółzinígíí bikáa'gi béésh bee hane'í bikáa' áají' hodíílnih éí doodaii' 1-888-926-4921 (TTY: 711).

**Persian (Farsi)**

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی 1-888-926-4921 (TTY: 711)

**Russian**

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочесть документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-888-926-4921 (TTY: 711).

**Panjabi (Punjabi)**

ਬਨਿ ਕਸਿ ਲਾਗਤ ਤੋ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀ ਇੱਕ ਦੁਭਾਸ਼ੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਰਿਪਾ ਕਰਕੇ 1-888-926-4921 (TTY: 711).

**Spanish**

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el 1-888-926-4921 (TTY: 711).

**Tagalog**

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tawagan ang 1-888-926-4921 (TTY: 711).

**Thai**

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-888-926-4921 (TTY: 711)

**Vietnamese**

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-888-926-4921 (TTY: 711).

# Glossary of Health Coverage and Medical Terms

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## Appeal

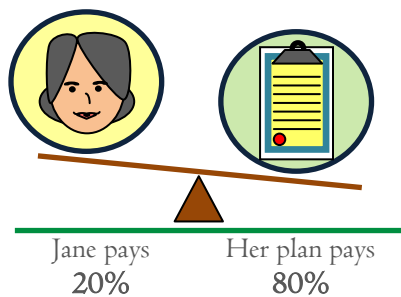
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(See page 4 for a detailed example.)

## Complications of Pregnancy

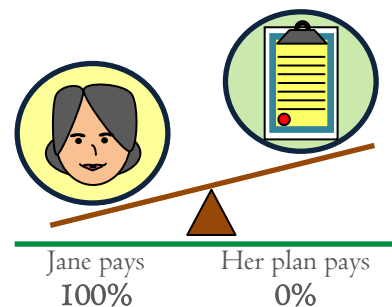
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

## 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.



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

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A complaint that you communicate to your health insurer or **plan**.

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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.

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A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

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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

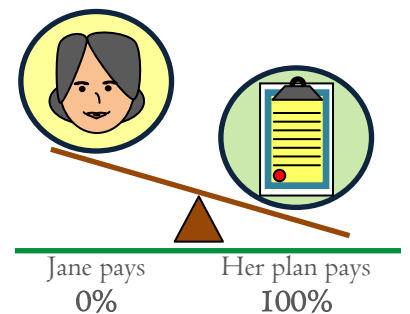
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

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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**.

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The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health



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## 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

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## 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.

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A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

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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

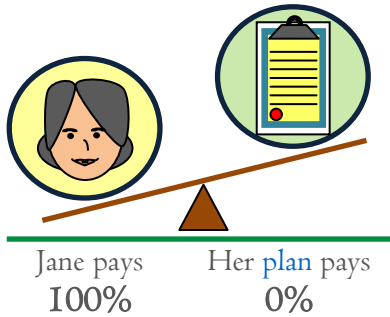
Jane's Plan Deductible: \$1,500

Co-insurance: 20%

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

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

December 31<sup>st</sup>  
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## Jane hasn't reached her \$1,500 deductible yet

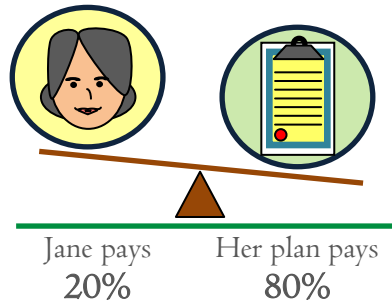
Her plan doesn't pay any of the costs.

Office visit costs: \$125

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more costs



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

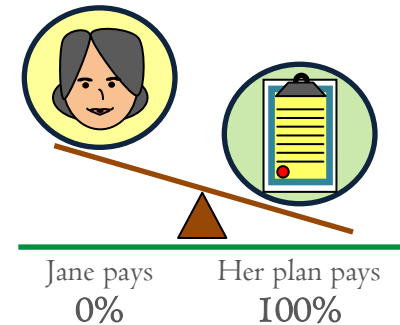
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more costs



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

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Office visit costs: \$200

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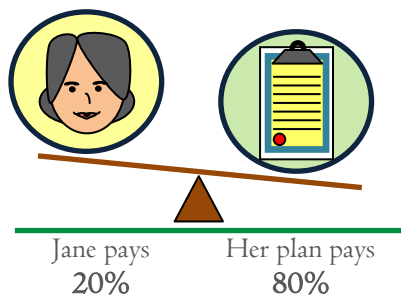
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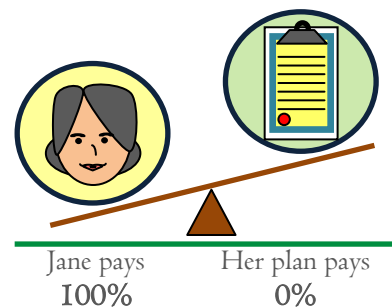
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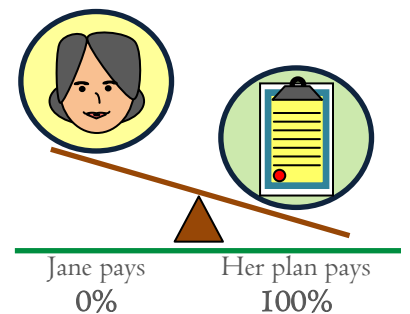
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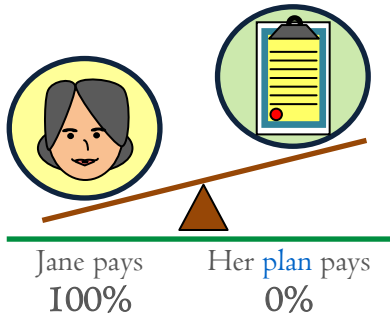
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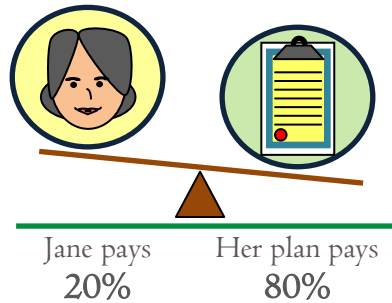
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more costs



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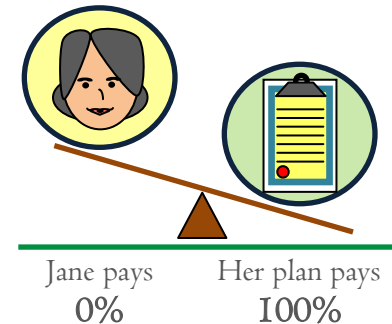
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