ARIZONA **BENEFIT SERVICES** DIVISION

ARIZONA DEPARTMENT OF ADMINISTRATION

A NOTICE FOR MEMBERS: SUMMARY OF BENEFITS AND COVERAGE

On February 9, 2011, as part of the Affordable Care Act (ACA), the federal government announced new rules regarding the disclosure of the Summary of Benefits and Coverage (SBC) and Uniform Glossary. These regulations apply to group health plans and health insurance issuers that offer coverage for groups and individuals. The purpose of these documents is to give consumers information so they can compare coverage options in different types of plans.

Frequently Asked Questions

What are the Summary of Benefits and Coverage (SBC)? It is a summary description of the health care benefits and coverage offered by your health insurance plan. It will include information like deductible amounts and co-insurance and co-payment obligations.

What is a Uniform Glossary? This is a list of commonly used health coverage and medical terms and their definitions. The U.S. Department of Health and Human Services has created the uniform glossary. The glossary includes definitions for health coverage and medical terms so you can compare and understand your coverage, your medical benefits and exclusions. The glossary is for information only and does not affect your coverage and benefits. If you ask for a written glossary, it must be provided to you within seven business days of your request to Benefit Services.

Where can I find the SBC and Uniform Glossary? The SBCs for the EPO, PPO, and HSA plans along with the uniform glossary will be posted electronically to the Benefit Options Website *benefitoptions.az.gov*.

When will I be provided an SBC? In addition to this notification, Benefit Services will provide the SBC during the following events:

Upon Initial Enrollment:
• You will be provided an e-mail or written notification with instructions on how to access the SBC documents on the Benefit Options Website with enrollment materials. • If information in the SBC changes between the time you apply for coverage and your first day of coverage, you will be provided an updated SBC no later than the first day of coverage.
At Open Enrollment:
• If a written application is required for renewal (paper or online), you will be provided an e-mail or written notification with instruction on how to access the SBC documents on the Benefit Options Website. • If renewal is automatic, you will be provided an e-mail or written notification with instructions on how to access the SBC documents on the Benefit Options Website 30 days prior to the new plan year.
If you have Special Enrollment or Qualified Life Event:
• You will be provided an e-mail or written notification with instructions on how to access the SBC documents on the Benefit Options Website no later than 90 days from enrollment.
Upon Request
• You will be provided a written SBC and/or Uniform Glossary within seven business days of your request. Please contact Benefit Services to request a copy.

How will the SBC be formatted? The format of the SBC will meet ACA requirements. For instance, it will be no longer than four double-sided pages, have a 12-point font and use terms that are understandable to the average member.

What information must be part of the SBC? The SBC will include all the information required by ACA rules. Some of that information will include the description of coverage, deductible amounts, and co-insurance obligations.

How will I receive the SBC? SBCs will be posted electronically on the Benefit Options Website. Members may also request a written copy from Benefit Services. If you and your dependents live at the same address, you will receive one SBC. However, if any of your dependents' last known addresses are different from yours, separate SBCs will be sent to those dependents' last known addresses.

- **Active and University Employees**
  An electronic notification will be sent to employees work e-mail listed in the personnel system. If no work e-mail is available a copy will be provided to the home address listed in the personnel system.

- **Retired Employees**
  Written notification will be provided with your enrollment materials to the home address listed in the personnel system.

- **COBRA Members**
  Written notification will be provided with your enrollment materials to the home address listed in the personnel system.

How do I request copies of the SBC? You may contact Benefit Services by phone, email, and fax or in person. Contact information has been included below.

Arizona Department of Administration
Benefit Services Division
100 N. 15th Ave., Suite 260
Phoenix, AZ 85007
Phone: 602.542.5008 or 1.800.304.3687
Fax: 602.542.4744
Website: *benefitoptions.az.gov*
E-mail: BenefitsIssues@azdoa.gov

Where do I find information about the health insurance marketplace? To obtain information about your health coverage and options available in the health insurance marketplace, please visit the Benefit Options website *benefitoptions.az.gov*.

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.benefitoptions.az.gov or by calling 1-602-542-5008 or 1-800-304-3687.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles 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 out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.benefitoptions.az.gov or call 1-602-542-5008 or 1-800-304-3687 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** payment of 20% would be $200.
- 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 in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** 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 provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay/visit	Not Covered	——————none——————
	Specialist visit	$30 co-pay/visit	Not Covered	——————none——————
	Other practitioner office visit	$10 co-pay/visit for OB/GYN	Not Covered	——————none——————
	Preventive care/screening/immunization	$15 co-pay/visit for primary care $10 co-pay/visit for OB/GYN	Not Covered	Screening limited to one visit per member per Plan Year. Age and frequency limits may apply. See your plan document for more information on limitations.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Some testing may require pre-certification. See your plan document for more information on pre-certification limitations.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.benefitoptions.az.gov.	Generic drugs	$10 co-pay/ prescription (retail) $20 co-pay/ prescription (mail order) $25 co-pay/ prescription (Choice90)	Not Covered	Covers up to a 30-day supply for retail; up to a 90-day supply for mail order; up to a 90-day supply for Choice90. Prescription medication with over-the-counter equivalents is not covered. Dispense as Written rules associated with how the plan will pay for a name-brand prescriptions may apply. See your plan document for more information on covered prescription drugs and limitations.
	Preferred brand drugs	$20 co-pay/ prescription (retail) $40 co-pay/ prescription (mail order) $50 co-pay/ prescription (Choice90)	Not Covered	
	Non-preferred brand drugs	$40 co-pay/ prescription (retail) $80 co-pay/ prescription (mail order) $100 co-pay/ prescription (Choice90)	Not Covered	
	Specialty drugs	$20 co-pay/ prescription	Not Covered	Limited to a 30-day supply. See your plan document for more information on Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 co-pay	Not Covered	Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fees	$15 primary care $15 OB/GYN $30 specialist	Not Covered	

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 immediate medical attention	Emergency room services	$125 co-pay	$125 co-pay	Must be a Medical Emergency as defined by your plan. Co-pay waived if admitted to hospital directly from emergency room but subject to hospital admission co-pay.
	Emergency medical transportation	No Charge	No charge	Non-medical emergency transportation requires pre-certification.
	Urgent care	$40 co-pay	Not Covered	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 co-pay	Not Covered	Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fee	No Charge	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 co-pay	Not Covered	See your plan document for more information on pre-certification limitations and excluded services.
	Mental/Behavioral health inpatient services	$150 co-pay	Not Covered	
	Substance use disorder outpatient services	$15 co-pay	Not Covered	
	Substance use disorder inpatient services	$150 co-pay	Not Covered	
If you are pregnant	Prenatal and postnatal care	$10 co-pay for OB/GYN	Not Covered	————————none————————
	Delivery and all inpatient services	No Charge	Not Covered	See your plan document for more information on pre-certification limitations.

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	Not Covered	Coverage is limited to 42 visits per member per plan year.
	Rehabilitation services	$15 co-pay	Not Covered	Coverage is limited to 60 visits per member per plan year.
	Habilitation services	Not Covered	Not Covered	——————none——————
	Skilled nursing care	No Charge	Not Covered	Coverage is limited to 90 days per member per plan year.
	Durable medical equipment	No Charge	Not Covered	See your plan document for more information on pre-certification limitations and excluded services.
	Hospice service	No Charge	Not Covered	See your plan document for more information on limitations and excluded services.
If your child needs dental or eye care	Eye exam	$15 physician co-pay	Not Covered	Screenings covered as part of well child health examination.
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult. Except for the treatment of an accidental injury to sound natural teeth where the continue course of treatment is started within six months of the accident.)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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.)

- Bariatric surgery (see plan document for information on limitations and exclusions)
- Chiropractic care (limited to 20 visits per member, per Plan Year)
- Hearing aids (limited to one per ear, per Plan year)
- Long-term care (Acute)
- Routine eye care (Adult, if part of a routine health examination)
- Routine foot care (if medically necessary)

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 1-602-542-5008 or 1-800-304-3687. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 Aetna at 1-866-217-1953 or www.aetna.com; Blue Cross Blue Shield of Arizona at 1-866-287-1980 or www.azblue.com; Cigna at 1-800-968-7366 or www.cigna.com/stateofaz; UnitedHealthcare at 1-800-896-1067 or www.myuhc.com; MedImpact at 1-888-648-6769 or www.benefitoptions.az.gov; or Benefit Options at 1-602-548-5008 or 1-800-304-3687 or www.benefitptions.az.gov.

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 1-602-542-5008 or 1-800-304-3687.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-602-542-5008 or 1-800-304-3687.

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

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** $7,450
- **Patient pays** $90

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
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$90
Co-insurance	$0
Limits or exclusions	$0
Total	**$90**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,100
- **Patient pays** $1,300

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
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$1,200
Co-insurance	$0
Limits or exclusions	$100
Total	**$1,300**

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, co-payments, and co-insurance 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 **co-payments**, **deductibles**, and **co-insurance**. 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.

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.benefitoptions.az.gov or by calling 1-602-542-5008 or 1-800-304-3687.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network **$500** employee **/ $1,000** family Out-of-network **$1,000** employee **/ $2,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles 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 out–of–pocket limit on my expenses?	Yes. In-network **$1,000** employee **/ $2,000** family Out-of-network **$4,000** employee **/ $8,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, drug co-pays, bariatric surgery coinsurance, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.benefitoptions.az.gov or call 1-602-542-5008 or 1-800-304-3687 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about **excluded services**.

Questions: Call 1-602-542-5008 or 1-800-304-3687 or visit us at www.benefitoptions.az.gov.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.benefitoptions.az.gov or call 1-602-542-5008 or 1-800-304-3687 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** 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 provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay/visit	50% co-insurance	——————none——————
	Specialist visit	$30 co-pay/visit	50% co-insurance	——————none——————
	Other practitioner office visit	$10 co-pay/visit for OB/GYN	50% co-insurance	——————none——————
	Preventive care/screening/immunization	$15 co-pay/visit for primary care $10 co-pay/visit for OB/GYN	50% co-insurance	Screening limited to one visit per member per Plan Year. Age and frequency limits may apply. See your plan document for more information on limitations.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% co-insurance	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	50% co-insurance	Some testing may require pre-certification. See your plan document for more information on pre-certification limitations.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.benefitoptions.az.gov.	Generic drugs	$10 co-pay/ prescription (retail) $20 co-pay/ prescription (mail order) $25 co-pay/ prescription (Choice90)	Not covered	Covers up to a 30-day supply for retail; up to a 90-day supply for mail order; up to a 90-day supply for Choice90. Prescription medication with over-the-counter equivalents is not covered. Dispense as Written rules associated with how the plan will pay for a name-brand prescriptions may apply. See your plan document for more information on covered prescription drugs and limitations.
	Preferred brand drugs	$20 co-pay/ prescription (retail) $40 co-pay/ prescription (mail order) $50 co-pay/ prescription (Choice90)	Not covered	
	Non-preferred brand drugs	$40 co-pay/ prescription (retail) $80 co-pay/ prescription (mail order) $100 co-pay/ prescription (Choice90)	Not covered	
	Specialty drugs	$20 co-pay/ prescription	Not covered	Limited to a 30-day supply. See your plan document for more information on Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 co-pay	50% co-insurance	Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fees	$15 primary care $15 OB/GYN $30 specialist	50% co-insurance	

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 immediate medical attention	Emergency room services	$125 co-pay	$125 co-pay	Must be a Medical Emergency as defined by your plan. Co-pay waived if admitted to hospital directly from emergency room but subject to hospital admission co-pay.
	Emergency medical transportation	No charge	No charge	Non-medical emergency transportation requires pre-certification.
	Urgent care	$40 co-pay	50% co-insurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 co-pay	50% co-insurance	Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fee	No charge	50% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 co-pay	50% co-insurance	See your plan document for more information on pre-certification limitations and excluded services.
	Mental/Behavioral health inpatient services	$150 co-pay	50% co-insurance	
	Substance use disorder outpatient services	$15 co-pay	50% co-insurance	
	Substance use disorder inpatient services	$150 co-pay	50% co-insurance	
If you are pregnant	Prenatal and postnatal care	$10 co-pay for OB/GYN	50% co-insurance	——————none——————
	Delivery and all inpatient services	No charge	50% co-insurance	See your plan document for more information on pre-certification limitations.

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	50% co-insurance	Coverage is limited to 42 visits per member per plan year.
	Rehabilitation services	$15 co-pay	50% co-insurance	Coverage is limited to 60 visits per member per plan year.
	Habilitation services	Not covered	Not covered	————————none————————
	Skilled nursing care	No charge	50% co-insurance	Coverage is limited to 90 days per member per plan year.
	Durable medical equipment	No charge	50% co-insurance	See your plan document for more information on pre-certification limitations and excluded services.
	Hospice service	No charge	50% co-insurance	See your plan document for more information on limitations and excluded services.
If your child needs dental or eye care	Eye exam	$15 physician co-pay	50% co-insurance	Screenings covered as part of well child health examination.
	Glasses	Not covered	Not covered	————————none————————
	Dental check-up	Not covered	Not covered	————————none————————

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult. Except for the treatment of an accidental injury to sound natural teeth where the continue course of treatment is started within six months of the accident.)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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.)

- Bariatric surgery (see plan document for information on limitations and exclusions)
- Chiropractic care (limited to 20 visits per member, per Plan Year)
- Hearing aids (limited to one per ear, per Plan year)
- Long-term care (Acute)
- Routine eye care (Adult, if part of a routine health examination)
- Routine foot care (if medically necessary)

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 1-602-542-5008 or 1-800-304-3687. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 Aetna at 1-866-217-1953 or www.aetna.com; Blue Cross Blue Shield of Arizona at 1-866-287-1980 or www.azblue.com; UnitedHealthcare at 1-800-896-1067 or www.myuhc.com; MedImpact at 1-888-648-6769 or www.benefitoptions.az.gov; or Benefit Options at 1-602-548-5008 or 1-800-304-3687 or www.benefitptions.az.gov.

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 1-602-542-5008 or 1-800-304-3687.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-602-542-5008 or 1-800-304-3687.

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

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** $6,460
- **Patient pays** $1,080

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
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Co-pays	$80
Co-insurance	$0
Limits or exclusions	$0
Total	**$1,080**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,200
- **Patient pays** $2,200

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
Total	**5,400**

Patient pays:

Deductibles	$1,000
Co-pays	$1,100
Co-insurance	$0
Limits or exclusions	$100
Total	**$2,200**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.

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.benefitoptions.az.gov or by calling 1-602-542-5008 or 1-800-304-3687.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network **$1,300** employee **$2,600** family Out-of network **$2,600** employee **/ $5,200** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. For non-preventive prescription drug coverage, **$1,300** employee **/ $2,600** family. There are no other specific **deductibles**.	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 out–of–pocket limit on my expenses?	Yes. In-network **$2,000** employee **/ $4,000** family Out-of network **$5,000** employee **/ $10,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.benefitoptions.az.gov or call 1-602-542-5008 or 1-800-304-3687 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about **excluded** services.

Questions: Call 1-602-542-5008 or 1-800-304-3687 or visit us at www.benefitoptions.az.gov.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.benefitoptions.az.gov or call 1-602-542-5008 or 1-800-304-3687 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** 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 provider's office or clinic	Primary care visit to treat an injury or illness	10% co-insurance	50% co-insurance	——————none——————
	Specialist visit	10% co-insurance	50% co-insurance	——————none——————
	Other practitioner office visit	10% co-insurance	50% co-insurance	——————none——————
	Preventive care/screening/immunization	No charge	50% co-insurance	Screening limited to one visit per member per Plan Year. Age and frequency limits may apply. See your plan document for more information on limitations.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance	50% co-insurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% co-insurance	50% co-insurance	Some testing may require pre-certification. See your plan document for more information on pre-certification limitations.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.benefitoptions.az.gov.	Generic drugs	Non-Preventive: 100% until deductible is met. Preventive: $10 co-pay (retail). $20 co-pay (mail order). $25 co-pay (Choice90)	Not covered	Covers up to a 30-day supply for retail; up to a 90-day supply for mail order; up to a 90-day supply for Choice90. Prescription medication with over-the-counter equivalents is not covered. See your plan document for more information on covered prescription drugs and limitations. Dispense as Written rules associated with how the plan will pay for a name-brand prescriptions may apply. See your plan document for more information on covered prescription drugs and limitations.
	Preferred brand drugs	Non-Preventive: 100% until deductible is met. Preventive: $20 co-pay (retail). $40 co-pay (mail order). $50 co-pay (Choice90)	Not covered	
	Non-preferred brand drugs	Non-Preventive: 100% until deductible is met. Preventive: $40 co-pay (retail). $80 co-pay (mail order). $100 co-pay (Choice90)	Not covered	

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
	Specialty drugs	$20 co-pay	Not covered	Limited to a 30-day supply. See your plan document for more information on Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	50% co-insurance	Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fees	10% co-insurance	50% co-insurance	
If you need immediate medical attention	Emergency room services	10% co-insurance	10% co-insurance	Must be a Medical Emergency as defined by your plan. Co-insurance waived if admitted to hospital directly from emergency room but subject to hospital admission co-pay.
	Emergency medical transportation	10% co-insurance	10% co-insurance	Non-medical emergency transportation requires pre-certification.
	Urgent care	10% co-insurance	50% co-insurance	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	50% co-insurance	Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fee	10% co-insurance	50% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% co-insurance	50% co-insurance	See your plan document for more information on pre-certification limitations and excluded services.
	Mental/Behavioral health inpatient services	10% co-insurance	50% co-insurance	
	Substance use disorder outpatient services	10% co-insurance	50% co-insurance	
	Substance use disorder inpatient services	10% co-insurance	50% co-insurance	
If you are pregnant	Prenatal and postnatal care	10% co-insurance	50% co-insurance	For initial diagnosis. Covered 100% thereafter.
	Delivery and all inpatient services	No charge	50% co-insurance	See your plan document for more information on pre-certification limitations.

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	10% co-insurance	50% co-insurance	Coverage is limited to 42 visits per member per plan year.
	Rehabilitation services	10% co-insurance	50% co-insurance	Coverage is limited to 60 visits per member per plan year.
	Habilitation services	10% co-insurance	50% co-insurance	————————none————————
	Skilled nursing care	10% co-insurance	50% co-insurance	Coverage is limited to 90 days per member per plan year.
	Durable medical equipment	10% co-insurance	50% co-insurance	See your plan document for more information on pre-certification limitations and excluded services.
	Hospice service	10% co-insurance	50% co-insurance	See your plan document for more information on limitations and excluded services.
If your child needs dental or eye care	Eye exam	10% co-insurance	50% co-insurance	Screenings covered as part of well child health examination.
	Glasses	Not covered	Not covered	————————none————————
	Dental check-up	Not covered	Not covered	————————none————————

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult. Except for the treatment of an accidental injury to sound natural teeth where the continue course of treatment is started within six months of the accident.)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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.)

- Bariatric surgery (see plan document for information on limitations and exclusions)
- Chiropractic care (limited to 20 visits per member, per Plan Year)
- Hearing aids (limited to one per ear, per Plan year)
- Long-term care (Acute)
- Routine eye care (Adult, if part of a routine health examination)
- Routine foot care (if medically necessary)

Your Rights to Continue Coverage:

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,870
- **Patient pays** $2,670

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
Total	**$7,540**

Patient pays:

Deductibles	$2,600
Co-pays	$0
Co-insurance	$70
Limits or exclusions	$0
Total	**$2,670**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,400
- **Patient pays** $2,000

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
Total	**$5,400**

Patient pays:

Deductibles	$800
Co-pays	$1,100
Co-insurance	$0
Limits or exclusions	$100
Total	**$2,000**

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**, **co-payments**, and **co-insurance** 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?

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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 **co-payments**, **deductibles**, and **co-insurance**. 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.

Glossary of Health Coverage and Medical Terms

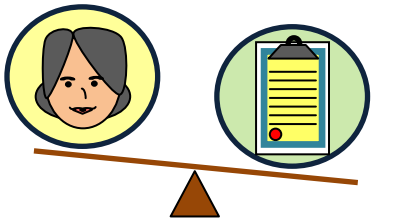
- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, 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.

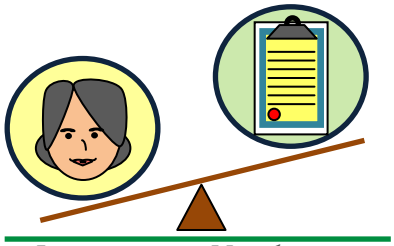


(See page 4 for a detailed example.)

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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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.

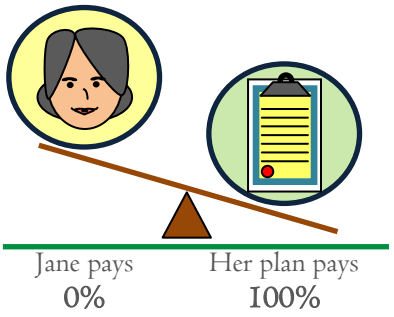
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

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.

(See page 4 for a detailed example.)

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

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

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

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

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

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

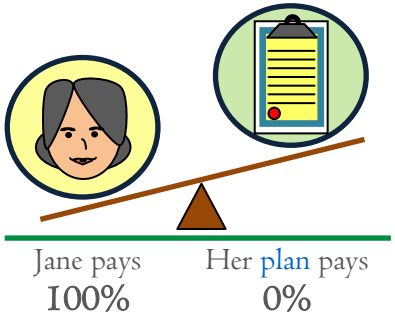
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

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

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

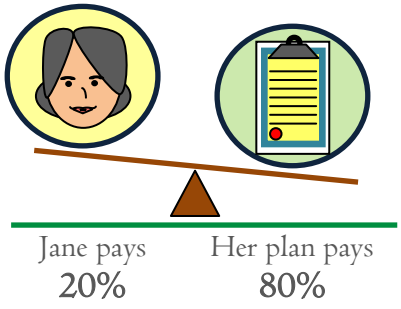


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

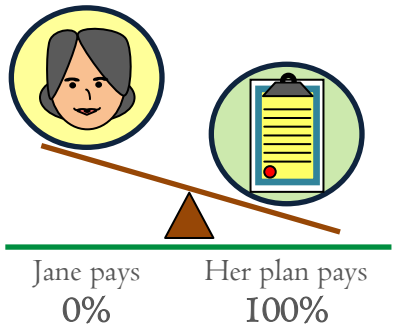


Jane reaches her $1,500 deductible, co-insurance begins

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