Employee Benefit Plan: Flathead Co. Non-Participating

Coverage Period: 07/01/2014-06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: Indemnity

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.askallegiance.com or by calling 1-800-877-1122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$800** Doesn't apply to preventive care, 2nd/3rd opinion, Accidental Injury.	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. **$300** for prescription drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,050**	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?	Copayments, Coinsurance, Premiums, 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?	No	This plan treats **providers** the same in determining payment for the same services.
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 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-877-1122 or visit us at www.askallegiance.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary attached.

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

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% Coinsurance	_____None_____
	Specialist visit	25% Coinsurance	_____None_____
	Other practitioner office visit	25% Coinsurance for chiropractor	Chiropractor coverage limited to 35 treatments, $25 max benefit per treatment, $100 max benefit for x-ray per Benefit Period.
	Preventive care/screening /immunization	No charge	_____None_____
If you have a test	Diagnostic test (x-ray, blood work)	25% Coinsurance	_____None_____
	Imaging (CT/PET scans, MRIs)	25% Coinsurance	_____None_____
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.askallegiance.com.	Generic drugs	10% Copayment Retail $7 min.; 10% Copayment Mail $14 min. *	Charges are payable only through the Plan's Pharmacy Benefit Management program. Coverage limited to 34-day supply retail; 90-day supply mail order. See plan for approved Mail Order Pharmacies. * per prescription Copayments may not apply to certain preventive care prescriptions.
	Preferred brand drugs	20% Copayment Retail $15 min.; 20% Copayment Mail $30 min. *	
	Non-preferred brand drugs	30% Copayment Retail $35 min.; 30% Copayment Mail $70 min. *	
	Specialty drugs	See retail as listed above for each of generic, preferred or non-preferred.	Specialty drugs must be obtained from a preferred specialty pharmacy. First prescription can be obtained at a network retail pharmacy. All subsequent refills must be obtained through a preferred specialty pharmacy.

Employee Benefit Plan: Flathead Co. Non-Participating

Coverage Period: 07/01/2014-06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: Indemnity

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% Coinsurance	_____None_____
	Physician/surgeon fees	25% Coinsurance	_____None_____
If you need immediate medical attention	Emergency room services	25% Coinsurance	_____None_____
	Emergency medical transportation	25% Coinsurance	_____None_____
	Urgent care	25% Coinsurance	_____None_____
If you have a hospital stay	Facility fee (e.g., hospital room)	25% Coinsurance	_____None_____
	Physician/surgeon fee	25% Coinsurance	_____None_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	25% Coinsurance	_____None_____
	Mental/Behavioral health inpatient services	25% Coinsurance	_____None_____
	Substance use disorder outpatient services	25% Coinsurance	_____None_____
	Substance use disorder inpatient services	25% Coinsurance	_____None_____
If you are pregnant	Prenatal and postnatal care	25% Coinsurance	_____None_____
	Delivery and all inpatient services	25% Coinsurance	_____None_____
If you need help recovering or have other special health needs	Home health care	25% Coinsurance	_____None_____
	Rehabilitation services	25% Coinsurance	_____None_____
	Habilitation services	25% Coinsurance	_____None_____
	Skilled nursing care	25% Coinsurance	_____None_____
	Durable medical equipment	25% Coinsurance	Pre-authorization recommended. Charges may be denied.
	Hospice service	25% Coinsurance	_____None_____
If your child needs dental or eye care	Eye exam	No Charge	Coverage limited to $200 Maximum Benefit per Benefit Period
	Glasses		

Questions: Call 1-800-877-1122 or visit us at www.askallegiance.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary attached.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
	Dental check-up	Not covered	Dental care is not covered under medical plan. Dental care is covered under excepted dental plan.

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
- Bariatric surgery
- Dental care (Adult) – Limits apply
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.

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.)**

- Chiropractic care
- Cosmetic surgery – Limits apply
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs –Limits apply

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 1-800-877-1122. 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: 1-800-877-1122 or visit us at www.askallegiance.com. 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/healthreform.

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.**

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** $5,490
- **Patient pays** $2,050

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
Copays	$0
Coinsurance	$1,050
Limits or exclusions	$0
Total	**$2,050**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact 1-800-877-1122.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,415
- **Patient pays** $1,985

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	$1,100
Copays	$260
Coinsurance	$325
Limits or exclusions	$300
Total	**$1,985**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-877-1122.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Questions: Call 1-800-877-1122 or visit us at www.askallegiance.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary attached.

Employee Benefit Plan: Flathead County Participating

Coverage Period: 07/01/2014-06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: Indemnity

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.askallegiance.com or by calling 1-800-877-1122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** "Best" Buy down; $**400** "Better" Buy down; **$600** "Good" Buy down. Doesn't apply to preventive care, 2nd/3rd opinion, Accidental Injury.	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. **$300** for prescription drug. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$1,450** "Best" Buy down; $**1,650** "Better" Buy down; **$1,850** "Good" Buy down.	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?	Pharmacy copayments, Premiums, 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?	No	This plan treats **providers** the same in determining payment for the same services.
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 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-877-1122 or visit us at www.askallegiance.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary attached.

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

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% Coinsurance	_____None_____
	Specialist visit	25% Coinsurance	_____None_____
	Other practitioner office visit	25% Coinsurance for chiropractor	Chiropractor coverage limited to 35 treatments, $25 max benefit per treatment, $100 max benefit for x-ray per Benefit Period.
	Preventive care/screening /immunization	No charge	_____None_____
If you have a test	Diagnostic test (x-ray, blood work)	25% Coinsurance	_____None_____
	Imaging (CT/PET scans, MRIs)	25% Coinsurance	_____None_____
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.askallegiance.com.	Generic drugs	10% Copayment Retail $7 min.; 10% Copayment Mail $14 min. *	Charges are payable only through the Plan's Pharmacy Benefit Management program. Coverage is limited to 30-day supply for retail; 90-day supply for mail order * per prescription Copayments may not apply to certain preventive care prescriptions.
	Preferred brand drugs	20% Copayment Retail $15 min.; 20% Copayment Mail $30 min. *	
	Non-preferred brand drugs	30% Copayment Retail $35 min.; 30% Copayment Mail $70 min. *	
	Specialty drugs	See retail as listed above for each of generic, preferred or non-preferred.	Specialty drugs must be obtained from a preferred specialty pharmacy. First prescription can be obtained at a network retail pharmacy. All subsequent refills must be obtained through a preferred specialty pharmacy.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% Coinsurance	_____None_____
	Physician/surgeon fees	25% Coinsurance	_____None_____
If you need immediate medical attention	Emergency room services	25% Coinsurance	_____None_____
	Emergency medical transportation	25% Coinsurance	_____None_____
	Urgent care	25% Coinsurance	_____None_____
If you have a hospital stay	Facility fee (e.g., hospital room)	25% Coinsurance	_____None_____
	Physician/surgeon fee	25% Coinsurance	_____None_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	25% Coinsurance	_____None_____
	Mental/Behavioral health inpatient services	25% Coinsurance	_____None_____
	Substance use disorder outpatient services	25% Coinsurance	_____None_____
	Substance use disorder inpatient services	25% Coinsurance	_____None_____
If you are pregnant	Prenatal and postnatal care	25% Coinsurance	_____None_____
	Delivery and all inpatient services	25% Coinsurance	_____None_____
If you need help recovering or have other special health needs	Home health care	25% Coinsurance	_____None_____
	Rehabilitation services	25% Coinsurance	_____None_____
	Habilitation services	25% Coinsurance	_____None_____
	Skilled nursing care	25% Coinsurance	_____None_____
	Durable medical equipment	25% Coinsurance	Pre-authorization recommended. Charges may be denied.
	Hospice service	25% Coinsurance	_____None_____
If your child needs dental or eye care	Eye exam	No charge	Coverage limited to $200 Maximum Benefit per Benefit Period
	Glasses		

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
	Dental check-up	Not covered	Dental care is not covered under medical plan. Dental care is covered under excepted dental plan.

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
- Bariatric surgery
- Dental care (Adult) – Limits apply
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.

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.)**

- Chiropractic care
- Cosmetic surgery – Limits apply
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs –Limits apply

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 1-800-877-1122. 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:

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Does this Coverage Provide Minimum Essential Coverage?

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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.**

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** $6,090
- **Patient pays** $1,450

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	$400
Copays	$0
Coinsurance	$1,050
Limits or exclusions	$0
Total	**$1,450**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact 1-800-877-1122.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,865
- **Patient pays** $1,535

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	$500
Copays	$260
Coinsurance	$475
Limits or exclusions	$300
Total	**$1,535**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-877-1122.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Questions: Call 1-800-877-1122 or visit us at www.askallegiance.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary attached.

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

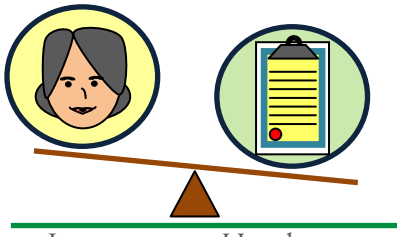
A request for your health insurer or **plan** to review a decision or a **grievance** again.

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.



Jane pays 20% | Her plan pays 80%

(See page 4 for a detailed example.)

Complications of Pregnancy

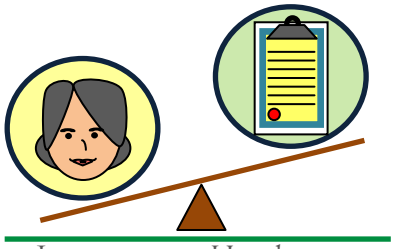
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

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.



Jane pays 100% | Her plan pays 0%

(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.

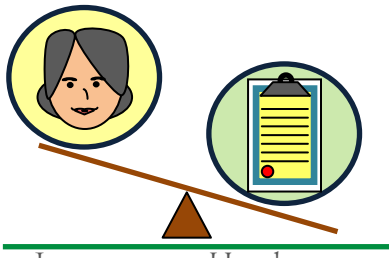
Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

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.

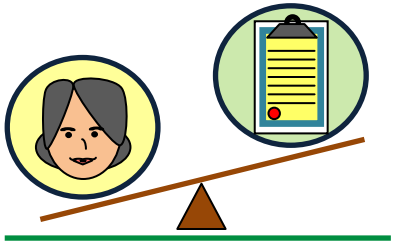
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

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



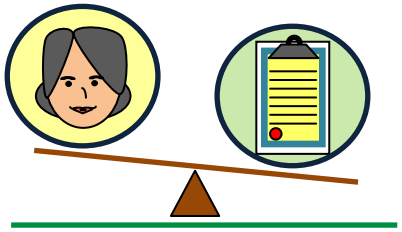
Jane pays 100% | Her plan pays 0%

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

Her plan doesn't pay any of the costs.

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

more costs



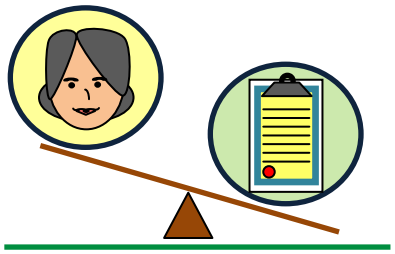
Jane pays 20% | Her plan pays 80%

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 pays 0% | Her plan pays 100%

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

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

Office visit costs: $200
Jane pays: $0
Her plan pays: $200