The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the Plan would share the cost for covered health care services. NOTE: Information about the cost of this Plan (called the premium) will be provided separately. For more information about your coverage, or if you want more detail about your coverage and costs, you can get the complete terms in the Plan document(s) by contacting your Benefits Administrator, by calling 1-866-673-2299 or by visiting us at cooperative.com > My Benefits. For definitions of common terms, such as allowed amount,[2] balance billing,[5] coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/or call 1-866-673-2299 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers $3,000/individual or $6,000/family; for out-of-network providers $6,000/individual or $12,000/family.	Generally, you must pay all of the costs, including the allowed amount,[2] from providers up to the deductible amount before this Plan begins to pay for covered services. If you have other family members on the Plan, the overall family deductible must be met before the Plan begins to pay for covered services for an individual.
Are there services covered before you meet your deductible?	Yes. Preventive care[1] services administered by network providers are not subject to the deductible.	This Plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this Plan covers certain preventive services[1] without cost-sharing and before you meet your deductible. See a list of covered preventive services[1] at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this Plan?	For network providers $3,000/individual or $6,000/family; for out-of-network providers $9,000/individual or $18,000/family.	The out-of-pocket limit is the most you could pay in a year for covered services. For network providers once you meet your network deductible ($3,000/individual or $6,000/family) and in-network coinsurance maximum ($0/individual or $0/family), you will meet your network provider out-of-pocket limit. For out-of-network providers once you meet your out-of-network deductible ($6,000/individual or $12,000/family) and out-of-network coinsurance maximum ($3,000/individual or $6,000/family), you will meet your out-of-network provider out-of-pocket limit.

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing[5] charges, penalties for failure to obtain Preauthorization[3] for services and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cooperative.com> My Benefits or call 1-866-673-2299 for a list of network providers.	This Plan uses a provider network. You will pay less if you use a provider in the Plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your Plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral. Preauthorization[3] and participation in the Center of Excellence (COE) is mandatory for both bariatric and transplant services.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge.	20% coinsurance	Subject to allowed amount.[2] If you consult with a Teladoc physician for a general medical condition, you pay $55/consultation until deductible is met.
	Specialist visit	No charge.	20% coinsurance	
	Preventive care[1]/screening/ Immunization	No charge.	20% coinsurance	Subject to allowed amount.[2] Age and gender limitations apply. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your Plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	20% coinsurance	Subject to allowed amount.[2]
	Imaging (CT/PET scans, MRIs)	No charge.	20% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required for all non-emergency, outpatient imaging.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cooperative.com> My Benefits	Generic drugs (Tier 1)	No charge.	20% coinsurance	Covers up to a 30-day supply (retail); up to a 90-day supply (mail order & Exclusive Choice pharmacies). Subject to allowed amount[2] and prior authorization[3] is required for compound drugs greater than $300, and specialty drugs and nonformulary drugs. Generic preventive drugs are available at no cost through the Exclusive Choice network (including mail order).
	Preferred brand drugs (Tier 2)	No charge.	20% coinsurance	
	Non-preferred brand drugs (Tier 3)	No charge.	20% coinsurance	
	Specialty drugs (Tier 4)	No charge.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	20% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required for inpatient hospital stays.
	Physician/surgeon fees	No charge.	20% coinsurance	Subject to allowed amount.[2]
If you need immediate medical attention	Emergency room care	No charge.	20% coinsurance	Subject to allowed amount,[2] copayment or coinsurance and deductible (if applicable).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	No charge.	No charge.	
	Urgent care: Part of a hospital	No charge.	20% coinsurance	**For outpatient Emergency room care visits that are not an actual medical emergency at an out-of-network provider will be subject to the out-of-network deductible and coinsurance.** **Note:** Urgent care is paid as an office visit, unless it is part of a hospital urgent care center.
	Urgent care: Not part of a hospital	No charge.	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	20% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required for inpatient hospital stays.
	Physician/surgeon fee	No charge.	20% coinsurance	Subject to allowed amount.[2]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge.	20% coinsurance	Subject to allowed amount.[2] If you consult with a Teladoc psychiatrist, you pay $220 for the initial consultation and $100 for each subsequent consultation until the deductible is met. If you consult with a Teladoc mental health, behavioral health, or substance abuse provider other than a psychiatrist, you pay $90 per consultation until the deductible is met. Applicable in-network coinsurance applies after the deductible is met. Preauthorization[3] is required for inpatient hospital stays. Partial hospitalization benefits are considered at the inpatient services benefit level.
	Inpatient services	No charge.	20% coinsurance	
If you are pregnant	Office visits	No charge.	20% coinsurance	Cost sharing does not apply to certain preventive services.[1] Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Subject to allowed amount.[2] Preauthorization[3] is required for inpatient hospital stays.
	Childbirth/delivery professional services	No charge.	20% coinsurance	
	Childbirth/delivery facility services	No charge.	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge.	20% coinsurance	Subject to allowed amount[2] and preauthorization.[3] Limited to 100 visits/ year.
	Rehabilitation services	No charge.	20% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required after visit limitation has been reached. Restorative speech therapy and chiropractic services are limited to 25 visits each. Acupuncture, physical, occupational, and massage therapy are limited to a combined 25 visits.
	Habilitation services	No charge.	20% coinsurance	Subject to allowed amount[2] and preauthorization.[3]
	Skilled nursing care	No charge.	20% coinsurance	Subject to allowed amount[2] and preauthorization[3] and limited to 90-day limit.
	Durable medical equipment	No charge.	20% coinsurance	Subject to allowed amount[2] and preauthorization[3] is required (if the dollar amount is equal to or greater than the following amounts) for rentals $500, prosthesis $1,000 and purchases $1,500.
	Hospice services	No charge.	No charge.	Subject to allowed amount.[2] Lifetime maximum for hospice services is $50,000.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	No coverage for these services.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or Plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care
- Eye exam
- Glasses
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside U.S.[4]
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the Plan at 1-866-673-2299. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your Plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your Plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your Plan. For more information about your rights, this notice, or assistance, contact Cooperative Benefit Administrators, Inc. at 1-866-673-2299. You may also contact the Department of Labor's Employee Benefits Security Administration at
1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

Does this Plan meet the Minimum Value Standards? **Yes**.
If your Plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-673-2299.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-673-2299.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-673-2299.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-673-2299.

Other Information:

1 **Preventive Services, Preventive Care:** Under Section 2713 of the Affordable Care Act, the plan must provide coverage for a range of preventive services and may not impose cost-sharing (such as copayments, deductibles, or co-insurance) on participants receiving these services. The required preventive services come from recommendations made by four expert medical and scientific bodies – the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA's) Bright Futures Project, and HRSA and the Institute of Medicine (IOM) committee on women's clinical preventive services. Only preventive services recommended by one of these four groups are covered without cost-sharing.

2 **Allowed Amount:** UCR - Referred to as Reasonable and Customary (R&C) Rates in the medical Plan materials, allowed amounts are the current, most common rates in a geographic area for a particular treatment or service. They are researched and reviewed by Cooperative Benefit Administrators, Inc. (CBA) on a regular basis.

3 **Preauthorize, Prior Authorization, or Prior Approval:**

- **Medical Plan Services and Supplies**. Failure to receive preauthorization for medical necessity will result in a 20% reduction in charges considered covered by the medical Plan. If such services or supplies are later determined not to be medically necessary, the services or supplies will be denied and not eligible for coverage under the medical Plan. You will be responsible for requesting preauthorization and the expenses for failure to obtain preauthorization. Exception: If you access the Choice Plus network, the provider is responsible for your preauthorization of a hospital in-patient admission and the expenses for failure to obtain preauthorization.
- **Prescription Drugs and Supplies**. Compound drugs greater than $300 and certain drugs and drug classes require Prior Authorization by either CBA or CVS Caremark. Refer to your medical Plan summary plan description for more information or contact CBA at 1-866-673-2299.

4 **Coverage While Traveling Outside the United States:** In order for a service obtained outside the U.S. to be covered, the information provided to the Plan must include the following: the service must be a recognized service in the U.S.; all provider billings and/or records must be translated into English; bills must clearly show the patient's name, provider's name, date of service, diagnosis and a description of the services rendered; and the current money exchange rate needs to be provided with the bill showing the daily rate for the dates the services were rendered. The participant is required to pay for all services up front before submitting charges to the Plan.

5 **Surprise billing and the No Surprises Act**: There are certain balance billing protections to protect consumers from getting a balance bill calculated at the out-of-network rate for out-of-network emergency services or when consumers have a scheduled procedure at an in-network hospital or surgery facility and are seen by an out-of-network provider. Note that some balance billing protections are waivable. Click here for more information.

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

About these Coverage Examples:

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

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

The Plan's overall deductible*	$3,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,000**

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

The Plan's overall deductible	$3,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,000**

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

The Plan's overall deductible	$3,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

***Note**:This charge does **NOT** include facility charges for the newborn baby. Charges for the newborn baby would be subject to the family deductible. If you have family coverage, you must meet the family deductible before this Plan begins to pay for covered services.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

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

Appeal

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

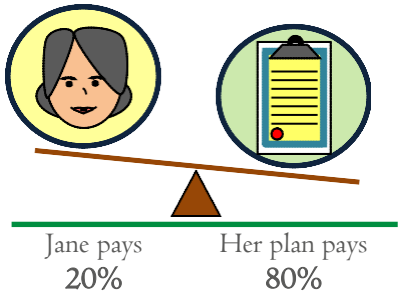
Balance Billing

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

Claim

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

Coinsurance



Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

(See page 6 for a detailed example.)

Complications of Pregnancy

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

Copayment

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

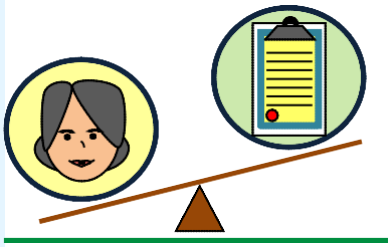
Cost Sharing

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

Cost-sharing Reductions

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

Deductible



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

Diagnostic Test

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

Durable Medical Equipment (DME)

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

Emergency Medical Condition

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

Emergency Medical Transportation

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

Emergency Room Care / Emergency Services

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

Excluded Services

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

Formulary

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

Grievance

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

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

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

Home Health Care

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

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

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

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

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

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

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

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

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

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

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

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

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

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

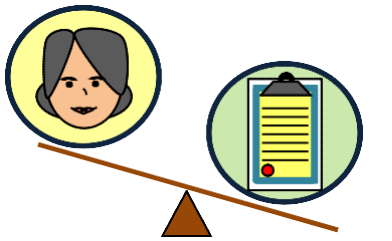
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

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

Out-of-pocket Limit



(See page 6 for a detailed example.)

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

Physician Services

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

Plan

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

Preauthorization

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

Premium

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

Premium Tax Credits

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

Prescription Drug Coverage

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

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

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

Primary Care Provider

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

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

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

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

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

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

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

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

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

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

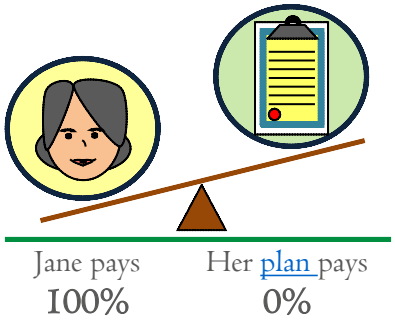
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

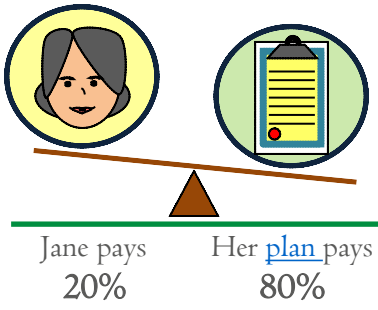
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

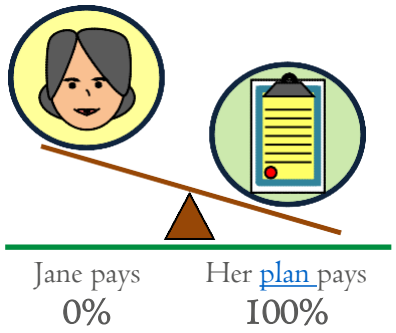
December 31st
End of Coverage Period



more costs



more costs



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

Her plan doesn't pay any of the costs.

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

Jane reaches her $1,500 deductible, coinsurance begins

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

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

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

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

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