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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.askallegiance.com or call 1-800-877-1122. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.coms.gov or call 1-800-877-1122 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Not Applicable.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$2,000 individual/$6,000 family, medical and pharmacy combined.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limits has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.askallegiance.com">www.askallegiance.com</a> or call 1-800-877-1122 for a list of network providers.</td>
<td>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 you 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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10 Copayment/visit</td>
<td>No benefit</td>
<td>Copayment applies to all services performed by the same provider on the same day.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$10 Copayment/visit</td>
<td>No benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>No benefit</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>No benefit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>No benefit</td>
<td></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$10 Copayment retail</td>
<td>No benefit</td>
<td>Charges payable through the Plan’s Pharmacy Benefit Manager (PBM) program. Copayments may not apply to certain PPACA preventive care prescriptions. Coverage is limited to 30 day supply for retail; 90 day supply for mail order. Prescriptions not obtained through the PBM are subject to 30% Coinsurance. Prior authorization required for certain prescriptions.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$10 Copayment retail</td>
<td>No benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$20 Copayment retail</td>
<td>No benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>$20 Copay generic</td>
<td>No benefit</td>
<td>Specialty drugs may be obtained from a specialty pharmacy. Coverage limited to 30 day supply.</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$10 Copayment/visit</td>
<td>No benefit</td>
<td>Pre-treatment review recommended for certain surgeries.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No benefit</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>No benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No benefit</td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$50 Copayment/visit</td>
<td>$50 Copayment/visit</td>
<td>Copayment waived if admitted as inpatient for emergency. Non-emergency use of the emergency room facility or provider is not covered.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$10 Copayment/visit</td>
<td>No benefit</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>No benefit</td>
<td>Pre-certification recommended for all inpatient admissions.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No benefit</td>
<td></td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com or call 1-800-877-1122.
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>$10 Copayment/visit for facility, individual therapy &amp; detoxification. $5 Copayment/visit for group therapy.</td>
<td>No benefit</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td>No charge</td>
<td>No benefit</td>
<td>Residential treatment facility limited to 100 days per benefit period. Pre-certification recommended for all inpatient admissions.</td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>$10 Copayment if billed per office visit</td>
<td>No benefit</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>No charge if billed as global fee</td>
<td>No benefit</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>No benefit</td>
<td>Pre-certification recommended for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section.</td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
<td>No benefit</td>
<td>Pre-treatment review recommended.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$10 Copayment/visit</td>
<td>No benefit</td>
<td>Coverage limited to 30 visits maximum per therapy type per benefit period. Pre-treatment review recommended.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$10 Copayment/visit</td>
<td>No benefit</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>No benefit</td>
<td>Coverage limited to 100 inpatient days per benefit period. Pre-certification recommended for all inpatient admissions.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>No benefit</td>
<td>One breast prosthetic appliance, 2 for bilateral mastectomy, per 12 months; up to 4 mastectomy bras per 12 months unless medically necessary. Pre-treatment review recommended for charges exceeding $5,000.</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>No benefit</td>
<td>Includes bereavement counseling. Pre-certification recommended for all inpatient admissions.</td>
<td></td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's eye exam</td>
<td>$10 Copayment/visit</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com or call 1-800-877-1122.
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your <strong>Plan</strong> Generally Does NOT Cover</th>
<th>Services Your Plan Generally Does NOT Cover</th>
<th>Services Your <strong>Plan</strong> Generally Does NOT Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
<td>• Hearing aids</td>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
<td>• Long-term care</td>
<td>• Weight loss programs</td>
</tr>
<tr>
<td>• Chiropractic care</td>
<td>• Non-emergency care when traveling outside of</td>
<td></td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
<td>the U.S.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services Your <strong>Plan</strong> Generally Does NOT Cover</th>
<th>Services Your Plan Generally Does NOT Cover</th>
<th>Services Your <strong>Plan</strong> Generally Does NOT Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Infertility treatment</td>
<td>• Private-duty nursing</td>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

### Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at: 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), or contact 1-800-877-1122 or [www.askallegiance.com](http://www.askallegiance.com). Additionally, a consumer assistance program can help you file your appeal. Consumer assistance programs available at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or [www.cciio.cms.gov/programs/consumer/capgrants/index.html](http://www.cciio.cms.gov/programs/consumer/capgrants/index.html).

### Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

---

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)

- **Plan's overall deductible**: $0
- **Specialist Copayment**: $10
- **Hospital (facility) Coinsurance**: 100%
- **Other Coinsurance**: 100%

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**: $12,731

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
</tbody>
</table>

**The total Peg would pay is**: $120

---

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

- **Plan’s overall deductible**: $0
- **Specialist Copayment**: $10
- **Hospital (facility) Coinsurance**: 100%
- **Other Coinsurance**: 100%

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**: $7,389

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$540</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$55</td>
</tr>
</tbody>
</table>

**The total Joe would pay is**: $595

---

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

- **Plan’s overall deductible**: $0
- **Specialist Copayment**: $10
- **Hospital (facility) Coinsurance**: 100%
- **Other Coinsurance**: 100%

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**: $1,925

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$30</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
</tbody>
</table>

**The total Mia would pay is**: $30

---

Note: The cost sharing amounts in the Coverage Examples are based on the CMS Cost Sharing Calculator (CECSC) [www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html](http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html) used to estimate out-of-pocket expenses. The coverage examples are estimated costs only, and may not accurately reflect actual costs. The actual care you receive will be different from these examples, and the cost of that care will also be different.

The plan would be responsible for the other costs of these EXAMPLE covered services.
Glossary of Health Coverage and Medical Terms

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

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

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

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

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

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

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

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

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

Cost-sharing Reductions
Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.
### Deductible
An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won’t pay anything until you’ve met your $1000 deductible for covered health care services subject to the deductible.)

<table>
<thead>
<tr>
<th>Jane pays</th>
<th>Her plan pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### 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.

---

**Glossary of Health Coverage and Medical Terms**
**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
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.

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.

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.

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.

Jane pays 0%
Her plan pays 100%
(See page 6 for a detailed example.)

See page 6 for a detailed example.

Glossary of Health Coverage and Medical Terms
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

Jane hasn't reached her $1,500 **deductible** yet
Her plan doesn't pay any of the costs.
- Office visit costs: $125
  - Jane pays: $125
  - Her plan pays: $0

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

Jane reaches her $5,000 **out-of-pocket limit**
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
- Office visit costs: $125
  - Jane pays: $0
  - Her plan pays: $125
Language Access Services: The information below is a requirement of Section 1557 of the Affordable Care Act effective August 18, 2016. It is required to assist those who may need assistance with the English language or translation assistance to a different language in which they are more fluent.

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-855-999-1062 (TTY：1-855-999-1063)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).


注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-999-1062（TTY:1-855-999-1063）まで、お電話にてご連絡ください。


