<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>Tier 1: $500 individual/$1,500 family &lt;br&gt;Tier 2: $1,500 individual/$4,500 family &lt;br&gt;Non-network: No benefit individual/family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care is not subject to deductible.</td>
<td>This plan covers some items and services even if you haven’t met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">http://www.healthcare.gov/coverage/preventive-care-benefits</a>.</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>Tier 1: $6,850 individual/$13,700 family&lt;br&gt;Medical and Pharmacy combined&lt;br&gt;Tier 2: $7,900 individual/$15,800 family&lt;br&gt;Non-network: No benefit individual/family</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/THT">www.askallegiance.com/THT</a> or call 1-855-999-1050 for a list of network providers.</td>
<td>This plan uses a provider network. You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. 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.</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>Tier 1 THT (Preferred Network in Clark County)</th>
<th>Tier 2 CIGNA (Preferred Network outside Clark County)</th>
<th>Non-Network Provider</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></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$10 copayment/visit deductible waived</td>
<td>$30 copayment/visit deductible waived</td>
<td>Not covered</td>
<td>Copayment applies only for evaluation and management. Additional charges are subject to deductible and coinsurance.</td>
<td></td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$20 copayment/visit deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge deductible waived</td>
<td>No charge deductible waived</td>
<td>Not covered</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>
<td></td>
</tr>
</tbody>
</table>

<p>| <strong>If you have a test</strong> | | | | | |
| Diagnostic test (x-ray, blood work) | No charge deductible waived Quest Laboratory or Freestanding Diagnostic Facility, 20% coinsurance deductible waived all other providers | 20% coinsurance | Not covered | None |
| Imaging (CT/PET scans, MRIs) | Freestanding Diagnostic Facility: CT Scan: $50 copayment deductible waived, MRI/MRA: $75 copayment deductible waived, PET Scan: $200 copayment deductible waived; CT Scan, MRI/MRA, PET Scan all other providers: 20% coinsurance deductible waived | 20% coinsurance | Not covered | None |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Tier 1 THT (Preferred Network in Clark County)</th>
<th>Tier 2 CIGNA (Preferred Network outside Clark County)</th>
<th>Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 (Generic) drugs</td>
<td>Retail Network Pharmacy*: $12 copayment per 30 day supply $36 copayment per 90 day supply</td>
<td>Courier Service (Alto Pharmacy): $10 copayment per 30 day supply $25 copayment per 90 day supply</td>
<td>Not covered</td>
<td>Charges payable through the plan’s pharmacy benefit manager program or exclusive network pharmacy. *Prescriptions filled at network pharmacies other than Alto, CVS, Walmart, Sam’s Club, Von’s, and Lin’s Supermarket (Overton, NV), are subject to a $10 pharmacy choice fee per prescription in addition to applicable copayments. Pharmacy choice fee does not apply to the out-of-pocket maximum. If Dispense as Written (DAW) is marked by the Physician with a brand drug, it will automatically be filled with a brand-name drug and member will be responsible for the difference between brand and generic plus the brand-name Copayment. Copayments may not apply to preventive care drugs as outlined in the Affordable Care Act (PPACA). Certain prescriptions require prior authorization before the drug can be dispensed.</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred brand) drugs</td>
<td>Retail Network Pharmacy* and Courier Service (Alto Pharmacy): 25% of the cost, copayment maximum of $100 per 30 day supply 25% of the cost, copayment maximum of $300 per 90 day supply</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-preferred brand) drugs</td>
<td>Retail Network Pharmacy* and Courier Service (Alto Pharmacy): 40% of the cost, copayment per 30 day supply 40% of the cost, copayment per 90 day supply</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Tier 1 (Generic): 25% of the cost, copayment maximum of $500 Tier 2 (Preferred): 25% of the cost, copayment maximum of $500 Tier 3 (Non-Preferred): 40% of the cost copayment</td>
<td>Not covered</td>
<td>Coverage limited to 30-day supply. First fill may be obtained at network retail. All subsequent fills must be obtained from Alto Pharmacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100 copayment deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Pre-treatment review recommended for certain surgeries.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care emergency services</td>
<td>$250 copayment deductible waived facility services 20% coinsurance after Tier 1 deductible provider services</td>
<td>Not covered</td>
<td>Copayment is waived if admitted as inpatient immediately following the emergency room visit.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency room care non-emergency services</td>
<td>$400 copayment deductible waived facility services 20% coinsurance after Tier 1 deductible provider services</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance deductible waived</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copayment/visit deductible waived</td>
<td>Not covered</td>
<td>Copayment applies to all charges for services provided at the urgent care facility.</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$400 copay/day $800 max/admit deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Pre-certification recommended for all inpatient admissions. Pre-treatment review recommended for certain surgeries.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees Inpatient primary care provider</td>
<td>No charge deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees Inpatient all other physician services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see the plan or policy document at [www.askallegiance.com/THT](http://www.askallegiance.com/THT) or call 1-855-999-1050.
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</tr>
</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Inpatient Facility services</td>
<td>$400 copay/day $800 max/admit deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Pre-certification recommended for all inpatient admissions. For Tier 1 services, contact THT Behavioral Health Network at (702) 780-0738. For Tier 2 services, contact Allegiance Care Management at (855) 999-1050. Mental health services include treatment for Autism Spectrum Disorder including Applied Behavior Analysis (ABA), Physical, Occupational and Speech Therapy, and nutritional counseling through age 18.</td>
</tr>
<tr>
<td></td>
<td>Inpatient/Outpatient provider services</td>
<td>$20 copay/visit deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residential Treatment Facility and partial hospitalization services</td>
<td>$150 copay/day $750 max/admit deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient facility services</td>
<td>$400 copay/day $800 max/visit deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office visit services</td>
<td>$10 copay/visit deductible waived</td>
<td>$30 copay/visit deductible waived</td>
<td>Not covered</td>
<td>Copayment applies only for evaluation and management. Additional charges are subject to deductible and coinsurance.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$10 copayment deductible waived if billed per office visit</td>
<td>$30 copayment deductible if billed per office visit</td>
<td>Not covered</td>
<td>Copayment applies only for evaluation and management. Additional charges are subject to deductible and coinsurance.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance deductible waived if billed as global fee</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Pre-certification recommended for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Pre-treatment review recommended.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$20 copay/visit deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Pre-treatment review recommended. Visits in excess of 30 visits per twelve-month period will be reviewed for Medical Necessity.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$20 copay/visit deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$400 copay/day $800 max/admit deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Pre-certification recommended for all inpatient admissions.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Pre-treatment review recommended. Benefit Limits: Compression garments 4 per limb per benefit period; bras 2 per benefit period; breast prosthesis 1 per breast every two benefit periods; prosthesis as part of bra 2 per benefit period.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance deductible waived</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Pre-certification recommended for all inpatient admissions.</td>
</tr>
</tbody>
</table>

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
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>
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<th>Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Dental care is not covered under the medical plan. Dental care is covered under an excepted benefit.</td>
</tr>
</tbody>
</table>

**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**.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)  
  - Infertility treatment
  - Long-term care
  - Routine eye care (Adult)
  - 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
- Chiropractic care  
  - Hearing aids
  - Non-emergency care when traveling outside of the U.S.
  - Private-duty nursing

**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), [www.askallegiance.com/THT](http://www.askallegiance.com/THT) or call 1-855-999-1050. 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.**

For more information about limitations and exceptions, see the plan or policy document at [www.askallegiance.com/THT](http://www.askallegiance.com/THT) or call 1-855-999-1050.
**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**: $500
- **Specialist copayment**: $20
- **Hospital (facility) copayment**: $400
- **Other coinsurance**: 20%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$460</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$479</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60

**The total Peg would pay is**: $999

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

- The **plan’s overall deductible**: $500
- **Specialist copayment**: $20
- **Hospital (facility) copayment**: $400
- **Other coinsurance**: 20%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$430</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,241</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $55

**The total Joe would pay is**: $1,726

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

- The **plan’s overall deductible**: $500
- **Specialist copayment**: $20
- **Hospital (facility) copayment**: $250
- **Other coinsurance**: 20%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$446</td>
</tr>
<tr>
<td>Copayments</td>
<td>$240</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$270</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

**The total Mia would pay is**: $956

---

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.)

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

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.

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.
**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.

(See page 6 for a detailed example.)

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

Jane has reached her $1,500 **deductible**, so coinsurance begins. She 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

**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
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.

**Language Access Services:**

English: Language assistance services are available to those who may need assistance with the English language. Call 1-855-999-1062 (TTY: 1-855-999-1063).

Arabic: Language assistance services are available to those who may need assistance with the English language or translation assistance to a different language in which they are more fluent. Call 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).

**ATANSON:** Si w pale Kreyòl Ayisyen, gen sèvis éd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS: 1-855-999-1063).


**ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 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。

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063) 번으로 전화해 주십시오.


**ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, gratuitos. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).