MUNICIPAL HEALTH BENEFIT FUND
P. O. BOX 188
NORTH LITTLE ROCK, ARKANSAS 72115
(501) 978-6137
(501) 537-7252 (FAX)
www.arml.org

QUICK REFERENCE CONTACT LIST

Customer Service
(501) 978-6137 Option #4
For Benefit and Claims Inquiries

Nurse Review (Pre-certification)
1-888-295-3591

Restat Pharmacy
1-855-253-0846
For Drug Card Inquiries

MHBF Board Exemptions for Little Rock

1. Elimination of the 30 day annual inpatient hospital limit
2. Additional Transplant per lifetime from 1 to 2;
3. Prescription Drug Reference Pricing opt out for the first quarter of coverage;
4. 30 day waiting period for new employees;
5. Coverage for dependents/spouses of employees killed in the line of duty with ordinance or policy;

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.arml.org\benefit_programs.html or by calling 1-501-978-6137.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500, 1,200 or $2,000 individual/$6,000 family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For in-state in-network medical providers. **$4,000** per individual, **$8,000** per family. For pharmacy providers, **$2,600** per individual, **$5,200** per family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, co-payments, penalty deductibles, balance billed charges, out of state and out of network care and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.arml.org or call 1-501-978-6137.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment and then 20% coinsurance	$20 copayment and then 50% coinsurance	--------None--------
	Specialist visit	$20 copayment and then 20% coinsurance	$20 copayment and then 50% coinsurance	--------None--------
	Other practitioner office visit	20% coinsurance	50% coinsurance	--------None--------
	Preventive care/screening/immunization	No charge	50% coinsurance	--------None--------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	
	Imaging (CT scans, Pet Scans, MRIs)	20% coinsurance	50% coinsurance	Coverage is limited to 2 PET scans per year
If you need drugs to treat your illness or condition	Generic drugs	$10/ prescription	Not covered	Coverage is limited to a 30 day supply per prescription
	Preferred brand drugs	$30/prescription	Not covered	
	Non-preferred brand drugs	$50/prescription	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.arml.org. **If you need drugs to treat your illness or condition.** More information about **prescription drug coverage** is available at www.arml.org	Reference-Priced drugs	Total cost of the dispensed drug less the total cost of the reference drug per prescription	Not covered	
	Specialty drugs up to $1,000; Specialty drugs up to $1,000.01 or higher	$50/ prescription $100/ prescription	Not covered	Coverage is limited to a 30 day supply per prescription and you must pre-certify by calling 866-285-2935.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center).	20% coinsurance	50% coinsurance	Coverage for elective surgery is limited to 2 surgeries annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to precertify.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	$250 copayment per visit and then 20% coinsurance	$250 copayment per visit and then 20% coinsurance	$250 copayment is waived if admitted to inpatient hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Coverage is limited to 2 ground and 2 air transports annually
	Urgent care	$20 copayment and then 20% coinsurance	$20 copayment and then 20% coinsurance	--------None--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Coverage is limited to 30 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to precertify.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health - outpatient services	20% coinsurance	50% coinsurance	Coverage is limited to 24 visits annually
	Mental/Behavioral health - inpatient services	20% coinsurance	50% coinsurance	Coverage is limited to 10 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to precertify.
	Substance abuse disorder – inpatient services	20% coinsurance	Not covered	Coverage is limited to 1 treatment plan, whether inpatient or outpatient per lifetime at MHBF Designated Chemical Dependency Center(s). You must pre-certify by calling 888-295-3591.
	Substance abuse disorder – outpatient services	20 % coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	--------None--------
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	You must pre-certify an extended inpatient stays by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.
If you need help recovering or have other special health needs.	Home health care	20% coinsurance	50% coinsurance	Coverage is limited to 20 visits annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.
	Rehabilitation services	20% coinsurance	50% coinsurance	Coverage is limited to 30 days for acute care and 15 days for sub-acute care, annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Habilitation Services	20% coinsurance	50% coinsurance	These services will be combined to allow a maximum of 30 visits annually with physical therapy, speech therapy and occupational therapy.
	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage is limited to 15 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.
	Durable medical equipment	20% coinsurance	50% coinsurance	--------None--------
	Hospice service	20% coinsurance	50% coinsurance	Coverage is limited to 90 days per lifetime. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery is only covered under the MBS-AQUIP Program
- Chiropractic care is limited to 12 visits annually
- Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 501-978-6137. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Municipal Health Benefit Fund at www.arml.org or 501-978-6137 or you may contact the Consumer Assistance Program of the Arkansas Insurance Department at insurance.consumers@arkansas.gov, 855-332-2227 or 501-371-2645.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 501-978-6137

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,610
- **Patient pays** $ 1,930

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$30
Coinsurance	$1,400
Limits or exclusions	$0
Total	**$1,930**

*This coverage example assumes self-only coverage (sometimes referred to as the individual coverage tier).

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,510
- **Patient pays** $ 890

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$50
Coinsurance	$340
Limits or exclusions	$0
Total	**$890**

*This coverage example assumes self-only coverage (sometimes referred to as the individual coverage tier).

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Privacy Notice

This notice describes how claims or medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

By law, the Municipal Health Benefit Fund (Fund) is required to protect the privacy of your protected health information. We must also give you this notice to tell you how the Fund may use and release ("Disclose") your protected health information possessed by the Fund.

The Fund must use and release your protected health information to provide information:

- To you or someone else who has the legal right to act for you (your personal representative)

- To the Secretary of the Department of Health and Human Services, if necessary to make sure your privacy is protected, and

- Where otherwise required by law.

The Fund has the right to use and release your protected health information to evaluate and process your health plan claims, to enroll and disenroll you and your dependents, and to perform related health plan operations.

For example:

- The Fund can use and disclose your protected health information to pay or deny your claims, to collect your premiums, or to share your benefit payment or status with health care providers or other health care payers.

- The Fund can use and disclose your protected health information for regular health-care operations. Staff may use information in your personal health record to improve the quality and effectiveness of the benefits and services we provide.

- The Fund may disclose to others who are contracted to provide services as business associates on our behalf. Some services are provided through contracts with others such as pharmacy management programs, copy and computer services, etc. Our contracts require these business associates to appropriately protect your information in compliance with applicable privacy and security laws.

The Fund may use or give out your protected health information for the following purposes, under limited circumstances:

- To state and federal agencies that have the legal right to receive Fund data (such as to make sure we are making proper claims payments)

- For public health activities (such as reporting disease outbreaks)

- For government health-care oversight activities (such as fraud and abuse investigations)

- For judicial and administrative proceedings (such as in response to a subpoena, law enforcement agency administrative request or other court order)

- For law enforcement purposes (such as providing limited information to locate a missing person or in response to any federal or state agency administrative request that is authorized by law)

- For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability)

- To avoid a serious and imminent threat to health or safety

- To contact you regarding new or changed health plan benefits

By law, the Fund must have your written permission (an "authorization") to use or release your protected health information for any purpose other than treatment, payment or healthcare operations or other limited exceptions outlined here or in federal privacy regulations or other applicable law.

For example, if you authorize the release of protected health information to your employer so to assist you in your claims for benefits, then the Fund may disclose protected health information to your employer.

Once you have given your permission for us to release your protected health information you may take it back ("revoke") at any time by giving written notice to us, except if we have already acted based upon your original permission.

To the extent (if any) that the Fund maintains or receives psychotherapy notes about you, most disclosures of these notes require your authorization specific to the release of such notes.

The Fund does not engage in fund raising activities where your protected health information is disclosed and the Fund does not sell protected health information.

Special Note on Genetic Information

The Fund does not and is also prohibited by law from collecting or using genetic information for purposes of underwriting, setting premium, determining eligibility for benefits or applying any preexisting condition exclusion under your health plan. Genetic information means not only genetic tests that you have received, but also any genetic tests of your family members, or any manifestations of a disease or disorder among your family members. The Fund might obtain and use genetic information in making a payment or denial decision or otherwise processing a claim for benefits under your health plan to the extent that genetic information is relevant to the payment or denial decision or proper processing of your claim.

Rights Regarding Medical Information about You

You have the right to:

•See and get a copy of your protected health information that is contained in a designated record set that was used to make decisions about you. This may include an electronic copy in certain circumstances if you make this request in writing.

•Have your protected health information amended if you believe that it is wrong, or if information is missing, and the Fund agrees. If the Fund disagrees, you may have a statement of your disagreement added to your protected health information.

•Receive a listing of those getting your protected health information from the Fund. The listing will not cover your protected health information that was given out to you or your personal representative, that was given out for payment or health-care operations, or that was given out for law enforcement purposes.

•Ask the Fund to communicate with you in a different manner or at a different place (for example, by sending your correspondence to a P.O. Box instead of your home address) if you are in danger of personal harm if the information is not kept confidential.

•Ask the Fund to limit how your protected health information is used and given out to pay your claims and perform health-care operations. Please note that the Fund may not be able to agree to your request.

•Get a separate paper copy of this notice.

Breach Notification:

In the event of breach of your unsecured health information, the Fund will provide you with notification of such a breach as required by law or where we otherwise deem such notification appropriate.

To Exercise Your Rights

If you would like to contact the Fund for further information regarding this notice or exercise any of the rights described in this notice, you may do so by contacting Customer Service at **501-978-6137.** You may also get complete instructions and request forms from: http://www.arml.org/benefit_programs.html

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Fund or with the Secretary of the Department of Health and Human Services. You may file a complaint with the Fund, by writing to the following address:

Municipal Health Benefit Fund
Attn: HIPAA Privacy and Security Officer
P.O. Box 38
North Little Rock, AR 72115

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

Changes to this Notice

We are required by law to abide by the terms of this notice. We reserve the right to change this notice and make the revised or changed notice effective for claims or medical information we already have about you as well as any future information we receive. When we make changes, we will notify you by sending a revised notice to the last known address we have for you or by alternative means allowed by law or regulation. We will also post a copy of the current notice at http://www.arml.org/benefit_programs.html

Revision date: 08/2014

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and ***may be different from the terms and definitions in the MHBF Fund Booklet.*** Some of these terms also might not have exactly the same meaning when used in your plan, and in any such case, the MHBF Fund Booklet governs:
- **Bold** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

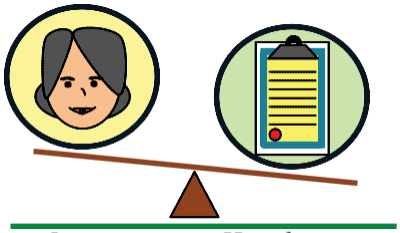
A request for your health **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount.** For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may not balance bill you for covered services.

Co-insurance

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



Jane pays	Her plan pays
20%	80%

(See page 4 for a detailed example.)

Complications of Pregnancy

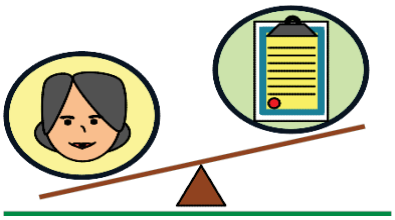
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

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

Deductible

The amount you owe for health care services your **health plan** covers before your health in plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Jane pays	Her plan pays
100%	0%

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

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

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition.**

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your **health plan** doesn't pay for or cover.

Grievance
A complaint that you communicate to your health **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 (MHBF is not Insurance)
A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

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

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

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

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered services to **providers** who contract with your **health plan.** In-network co-insurance usually costs you less than **out-of-network co-insurance.**

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to **providers** who contract with your **health plan**. In-network co-payments usually are less than **out-of-network co-payments.**

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

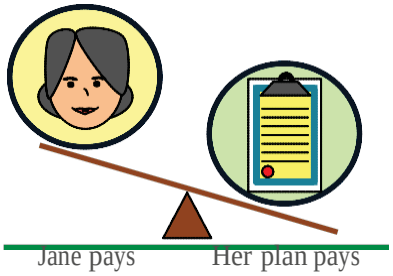
Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A **provider** who doesn't have a contract with your health plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health plan, or if your health plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do not contract with your **health plan**. Out- of-network co-insurance usually costs you more than **in- network co-insurance.**

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

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your **health plan** begins to pay 100% of the **allowed amount.** This limit never includes your **premium, balance-billed** charges or health care your health plan doesn't cover. Some health plans don't count all of **your co-payments, deductibles, co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

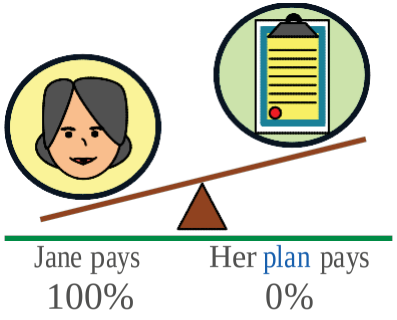
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care.**

How You and Your Insurer Share Costs - Example

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

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

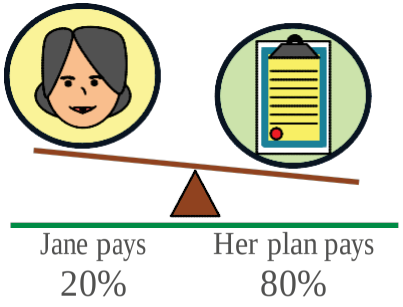


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

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

more costs

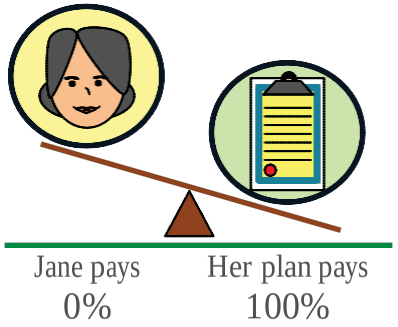


Jane reaches her $1,500 deductible, co-insurance begins

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

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



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

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

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