



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 [AXAXL-quantum.com](http://AXAXL-quantum.com) or call 1-844-460-2821. For 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](http://www.dol.gov/ebsa/healthreform) and [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-877-1122 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | \$750 individual/\$1,500 family network,<br>\$2,500 individual/\$5,000 family non-network                                                                                              | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> (embedded) until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                                                                     |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. Preventive care and immunizations are not subject to <a href="#">deductible</a> .                                                                                                 | This <a href="#">plan</a> covers some items and services even if you haven't met the <a href="#">deductible</a> amount, but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">http://www.healthcare.gov/coverage/preventive-care-benefits</a> .                                                                                                                                   |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | Yes. \$125 individual/\$250 family for <a href="#">prescription drug coverage</a> . \$50 Home Health Care annual deductible. There are no other specific <a href="#">deductibles</a> . | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | \$3,000 individual/\$6,000 family network,<br>\$6,000 individual/\$12,000 family non-network<br>Pharmacy: \$1,250 individual/\$2,500 family network and non-network                    | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> (embedded) until the overall family <a href="#">out-of-pocket limits</a> has been met.                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> , <a href="#">balance billing</a> charges (unless <a href="#">balanced billing</a> is prohibited), and health care this <a href="#">plan</a> doesn't cover.   | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://AXAXL-quantum.com">AXAXL-quantum.com</a> or call 1-844-460-2821 for a list of <a href="#">network providers</a> .                                             | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You pay the least if you use a <a href="#">provider</a> in Tier 1. You pay more if you use a <a href="#">provider</a> in Non-Tier 1. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | No                                                                                                                                                                                     | You can see the <a href="#">specialist</a> you choose without a referral.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                                                                                                                                                          | Services You May Need                                  | Tier 1                                                       | Non-Tier 1                       | Out-Of-Network                   | Limitations & Exceptions & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------|----------------------------------|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                 | Primary care (PCP) visit to treat an injury or illness | \$10 copayment deductible waived                             | \$25 copayment deductible waived | 40% coinsurance after deductible | Copayment applies to all services performed in the office by the same provider on the same day as the office visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                               | <a href="#">Specialist</a> (SCP) visit                 | \$25 copayment deductible waived                             | \$50 copayment deductible waived | 40% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                               | <a href="#">Preventive care/screening/immunization</a> | No charge deductible waived                                  | No charge deductible waived      | 40% coinsurance after deductible | You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you have a test</b>                                                                                                                                                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)    | Not applicable                                               | 20% coinsurance after deductible | 40% coinsurance after deductible | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                               | Imaging (CT/PET scans, MRIs)                           | Not applicable                                               | No charge deductible waived      | 40% coinsurance after deductible | Preauthorization required for MRI/MRA and PET scans.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> . | Generic drugs                                          | \$10 copayment retail<br>\$20 copayment mail order           |                                  | 40% coinsurance after deductible | Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program. If Physician does not prescribe "Dispense as Written" (DAW), and there is a generic alternative, and covered person chooses a brand name instead, covered person must pay the difference in cost between generic and brand plus applicable brand copayment amount. Certain maintenance medications are available at a 90 day supply at select pharmacies. Coverage is limited to 30 day supply for retail; 90 day supply for mail order through CVS network pharmacy. Certain prescriptions require prior authorization before the drug can be dispensed or before obtaining a second fill. Administered by Archimedes. Contact 1-888-419-0825 for more information. Coverage is limited to 30 day supply. |
|                                                                                                                                                                                                               | Preferred brand drugs                                  | 30% coinsurance after deductible                             |                                  | 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                               | Non-preferred brand drugs                              | 40% coinsurance after deductible                             |                                  | 60% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                               | <a href="#">Specialty drugs</a>                        | See as listed above for generic, preferred and non-preferred |                                  | Not covered                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>If you have outpatient surgery</b>                                                                                                                                                                         | Facility fee (e.g., ambulatory surgery center)         | Not applicable                                               | 20% coinsurance after deductible | 40% coinsurance after deductible | Preauthorization required for outpatient surgeries.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                               | Physician/surgeon fees                                 | 10% coinsurance after deductible                             | 20% coinsurance after deductible | 40% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>If you need immediate medical attention</b>                                                                                                                                                                | <a href="#">Emergency room care</a>                    | \$150 copayment deductible waived                            |                                  |                                  | Copayment waived if admitted, and inpatient hospital benefits will apply                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                               | <a href="#">Emergency medical transportation</a>       | 20% coinsurance after network deductible                     |                                  |                                  | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                               | <a href="#">Urgent care</a>                            | Not applicable                                               | \$50 copayment deductible waived |                                  | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you have a hospital</b>                                                                                                                                                                                 | Facility fee (e.g., hospital room)                     | Not applicable                                               | 20% coinsurance after deductible | 40% coinsurance after deductible | Preauthorization required for all inpatient admissions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

For more information about limitations and exceptions, see the plan or policy document at [AXAXL-quantum.com](http://AXAXL-quantum.com) or call 1-844-460-2821.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                             | Services You May Need                     | Tier 1                                                                                   | Non-Tier 1                                                                               | Out-Of-Network                   | Limitations & Exceptions & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>stay</b>                                                                      | Physician/surgeon fees                    | 10% coinsurance after deductible                                                         | 20% coinsurance after deductible                                                         | 40% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Office visits                             | Not applicable                                                                           | \$10 copayment deductible waived                                                         | 40% coinsurance after deductible | None                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                  | Outpatient services                       | Not applicable                                                                           | 10% coinsurance after deductible                                                         | 40% coinsurance after deductible | Preauthorization required for intensive outpatient mental health/substance use disorders.                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                  | Inpatient services                        | Not applicable                                                                           | 10% coinsurance after deductible                                                         | 40% coinsurance after deductible | Preauthorization required for all inpatient admissions.                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>If you are pregnant</b>                                                       | Office visits                             | \$10 copayment PCP<br>\$25 copayment SCP<br>deductible waived if billed per office visit | \$25 copayment PCP<br>\$50 copayment SCP<br>deductible waived if billed per office visit | 40% coinsurance after deductible | Preauthorization required for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. Cost sharing does not apply for preventive services. Primary care or specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, deductible and coinsurance or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                                  | Childbirth/delivery professional services | 10% coinsurance after deductible if billed as a global fee                               | 20% coinsurance after deductible if billed as a global fee                               | 40% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                  | Childbirth/delivery facility services     | Not applicable                                                                           | 20% coinsurance after deductible                                                         | 40% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | Not applicable                                                                           | 20% coinsurance after deductible                                                         | 25% coinsurance after deductible | Preauthorization required for home health care services.                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                  | <a href="#">Rehabilitation services</a>   | \$10 copayment PCP<br>\$25 copayment SCP<br>deductible waived                            | \$25 copayment PCP<br>\$50 copayment SCP<br>deductible waived                            | 40% coinsurance after deductible | Coverage limited to 90 days in network and 45 days out of network for all therapy types combined.                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                  | <a href="#">Habilitation services</a>     | \$10 copayment PCP<br>\$25 copayment SCP<br>deductible waived                            | \$25 copayment PCP<br>\$50 copayment SCP<br>deductible waived                            | 40% coinsurance after deductible | None                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                  | <a href="#">Skilled nursing care</a>      | Not applicable                                                                           | 20% coinsurance after deductible                                                         | 40% coinsurance after deductible | Coverage limited to 120 days. Preauthorization required for all inpatient and skilled nursing facility admissions.                                                                                                                                                                                                                                                                                                                                    |
|                                                                                  | <a href="#">Durable medical equipment</a> | Not applicable                                                                           | 20% coinsurance after deductible                                                         | 40% coinsurance after deductible | Preauthorization required for charges exceeding \$1,500.                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                  | <a href="#">Hospice services</a>          | Not applicable                                                                           | 20% coinsurance after deductible                                                         | 40% coinsurance after deductible | Includes bereavement counseling as a part of the hospice program. Preauthorization required for hospice care.                                                                                                                                                                                                                                                                                                                                         |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | Not covered                                                                              |                                                                                          |                                  | None                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                  | Children's glasses                        | Not covered                                                                              |                                                                                          |                                  | None                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                  | Children's dental check-up                | Not covered                                                                              |                                                                                          |                                  | None                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

## Excluded Services & Other Covered Services:

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

- |                       |                                                         |                            |
|-----------------------|---------------------------------------------------------|----------------------------|
| • Cosmetic surgery    | • Long-term care                                        | • Routine eye care (Adult) |
| • Dental care (Adult) | • Non-emergency care when traveling outside of the U.S. | • Weight loss programs     |

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

- |                                      |                         |                                              |
|--------------------------------------|-------------------------|----------------------------------------------|
| • Acupuncture                        | • Hearing aids          | • Private-duty nursing (medically necessary) |
| • Bariatric surgery (with exception) | • Infertility treatment | • Routine foot care (medically necessary)    |
| • Chiropractic care                  |                         |                                              |

**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), [AXAXL-quantum.com](http://AXAXL-quantum.com) or call 1-844-460-2821. 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

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

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

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$750 |
| ■ <a href="#">Specialist</a> copayment                          | \$50  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

\*Coverage example is based on Non-Tier 1 provider benefits.

#### 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$750          |
| Copayments                        | \$0            |
| Coinsurance                       | \$2,300        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,060</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$750 |
| ■ <a href="#">Specialist</a> copayment                          | \$50  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

\*Coverage example is based on Non-Tier 1 provider benefits.

#### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$875          |
| Copayments                        | \$400          |
| Coinsurance                       | \$700          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,995</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$750 |
| ■ <a href="#">Specialist</a> copayment                          | \$50  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

\*Coverage example is based on Non-Tier 1 provider benefits.

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$800          |
| Copayments                        | \$300          |
| Coinsurance                       | \$200          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,300</b> |

**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.

# 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

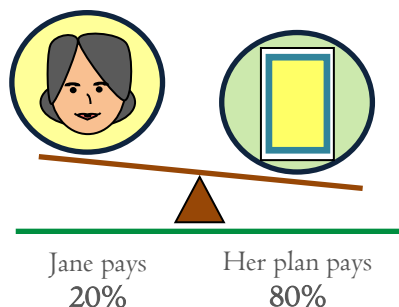
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you 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 balance 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 (sometimes called “copay”). The amount can vary by the type of covered health care service.

## Cost Sharing

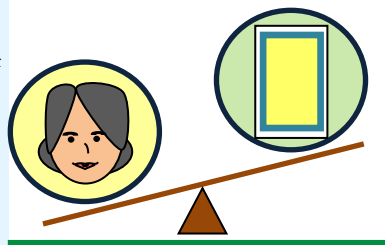
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) 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.)

## Diagnostic Test

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

## Durable Medical Equipment (DME)

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

## Emergency Medical Condition

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

## Emergency Medical Transportation

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

## Emergency Room Care / Emergency Services

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

## Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

## Formulary

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

## Grievance

A complaint that you communicate to your health insurer or [plan](#).

## Habilitation Services

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

## Health Insurance

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

## Home Health Care

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

## Hospice Services

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

## Hospitalization

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

## Hospital Outpatient Care

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

## In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered health care 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

Minimum essential coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the [premium tax credit](#).

## 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)

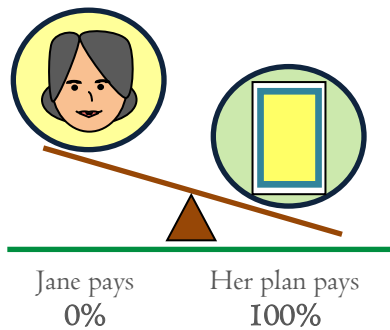
A [provider](#) who doesn’t have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called “non-preferred” 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%

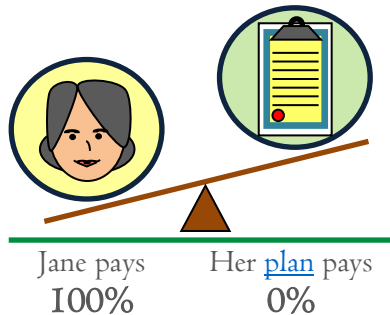
Out-of-Pocket Limit: \$5,000

January 1<sup>st</sup>

Beginning of Coverage Period

December 31<sup>st</sup>

End of Coverage Period



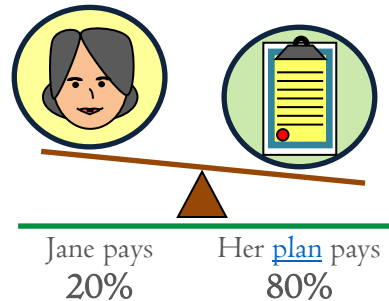
## Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0



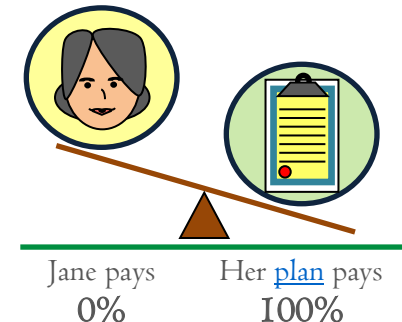
## Jane reaches her \$1,500 deductible, coinsurance begins

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.**

فتاهبكم: (1-855-999-1062 . مقر) 1063-999-855 مقبر صلتا . نجاملبا لك فراوتت يتوغللا ةعدهاملا تامدخ نإف ،تغللا ركذا ثدحتت ننتك إذ :تظوحم  
لاو ملصا

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).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd 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).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 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.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. 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).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).