National Association of Insurance Commissioners
& The Center for Insurance Policy and Research

March 18, 2016

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Thomas E. Perez
Secretary
U.S. Department of Labor
200 Constitution Ave., N.W.
Washington, D.C. 20210

The Honorable Jacob J. Lew
Secretary
U.S. Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Secretaries Burwell, Perez and Lew:

We appreciate the opportunity to comment on the revised Summary of Benefits and Coverage (SBC) and Uniform Glossary (81 Fed. Reg. 38, 9860 (Feb. 26, 2016)), which includes a new set of proposed SBC templates, instructions, and an updated uniform glossary (February 2016 materials). We write as the chief insurance regulators of our respective states and officers of the National Association of Insurance Commissioners (NAIC).

In the Spring of 2015, the NAIC convened the Consumer Information (B) Subgroup (Subgroup) comprised of regulators and an Advisory Working Group of consumer representatives, industry representatives and provider groups to develop a revised SBC template, insurer instructions, and a uniform glossary. The Subgroup met twice weekly throughout the Spring, Summer and Fall, and after conducting consumer testing and making further revisions, submitted its formal recommendation for the SBC template and instructions on October 14, 2015 (October 2015 template). Subgroup recommendations for the uniform glossary were submitted by the NAIC on December 8, 2015. In late December, we learned that representatives of the Departments of Labor, Health and Human Services, and the Treasury (the Tri-Agencies) had determined that the statutory 4-page limit for the SBC required condensing of our October 2015 template.

Although the NAIC maintains that the October 2015 template is preferable because it reflects a product that was consumer tested, we acknowledge your efforts to keep many of the Subgroup's recommendations contained in the October 2015 template. We believe these changes improve the quality of information presented. Unfortunately, we would be remiss in our obligations as insurance

regulators if we did not again note the negative impact the page limitation will have on consumers. Important consumer information is being omitted for the sake of meeting this page limitation. The page limitation results in an SBC that is very dense in terms of the information presented. The page limitation has also resulted in the elimination of important design elements that consumer testing revealed were necessary, in particular, for consumers with low health coverage literacy.

In light of the above, we again want to stress that as the Tri-Agencies consider future updates to the SBC, the Tri-Agencies should engage the NAIC early in the planning process. Future plans should contemplate adequate time to allow the Subgroup to undertake robust consumer testing at the beginning of the process, to inform a thoughtful and collaborative discussion with stakeholders, as well as at the conclusion, to affirm and validate the overall performance of the SBC. This type of process would ensure that the final product reflects strong consumer-oriented content and design elements, both of which will directly benefit consumers across the country.

With regard to the revised SBC template you recently released, the attached Addendum provides a summary of the collective feedback of the Subgroup, including the Advisory Working Group members, on the revised February 2016 proposed SBC template and instructions. We flagged general areas of concern, as well as made specific recommendations for improvement, where possible.

We remain ready and willing to provide any additional assistance or review regarding these documents. Please contact us with any questions.

Sincerely,

John M. Huff
NAIC President
Director
Missouri Department of Insurance,
Financial Institutions and Professional Registration

Ted Nickel
NAIC President-Elect
Commissioner
Wisconsin Office of the
Insurance Commissioner

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NAIC Secretary-Treasurer
Superintendent
Maine Bureau of Insurance

Enclosure: Addendum

ADDENDUM

I. Implementation Timeline

- The Subgroup's insurer representatives remind the Tri-Agencies to remain cognizant of the challenges, technical and otherwise, inherent in implementing the revised SBC. Sufficient time to allow review and approval of the forms by state insurance regulators is necessary in many instances. Insurer representatives would appreciate guidance as to how to coordinate filing with state regulators and federal and state exchanges. Additionally, the industry would appreciate the cost calculator as soon as possible.

- The Subgroup's consumer representatives emphasize consumers' need to realize the benefit of the improved SBC template as soon as possible. The consumer representatives express disappointment in the delayed implementation for most carriers until 2018 and oppose any further delay.

II. General Formatting Concerns

- While the proposed revised SBC provides flexibility in terms of margins (to alleviate space concerns), the Subgroup's insurer representatives remain concerned about technical hardware obstacles which may prevent plans and issuers from meeting the page limit. Specifically, as the Tri-Agencies still require printed versions of the SBC to be provided, printer hardware and/or software may not permit such flexibility in margins. This is of particular concern with the Coverage Examples and the insurer representatives ask that the Tri-Agencies provide guidance on how the information should be handled should a second page be necessary due to margin limitations.

- The instructions allow plans and issuers to include in the SBC "Barcodes, control numbers, or other similar language…for quality control purposes." The NAIC October submission included this same language, as well as the following additional flexibility: "Page numbers may be relocated along the bottom of pages to accommodate barcodes, control numbers or other similar language." The Subgroup's insurer representatives have learned that page numbers need to be relocated before their printer hardware and/or software is able to include the barcode. An allowance to relocate page numbers should be restored.

- The instructions for "Other significant limitations, exceptions, and other important information" under the "Limitations, Exceptions, & Other Important Information column" state:

  > If there are no items that meet the significance threshold described above, then the plan or issuer should show "----------None----------" for each Common Medical Event in the chart, the plan or issuer should merge the boxes in the *Limitations, Exceptions, and Other Important Information* column and display one response across multiple rows if such a merger would lessen the need to replicate comments and would save space.

  The Subgroup's insurer representatives have identified that including the dashes creates significant programming issues and requests that the instructions allow plans and issuers to show "none" without the required dashes.

- Page limits are also an issue with translated SBCs and guidance is requested.

III. Allow Cross-Referencing to Other Relevant Documents

- The Subgroup identified a couple of issues with the following instruction in the "General Instructions":

> The SBC is not permitted to substitute a cross-reference to the SPD or other documents for any content element of the SBC, except as permitted in the *Limitations, Exceptions, and Other Important Information* column. However, an SBC may include a reference to the SPD in the box at the top of the first page of the SBC. (For example, "Questions: Call 1-800-[insert] or visit us at www.[insert].com for more information, including a copy of your plan's summary plan description.") In addition, wherever an SBC provides information that fully satisfies a particular content element of the SBC, it may add to that information a reference to specified pages or sections of the SPD in order to supplement or elaborate on that information.

First, this same instruction is included in both the individual and group instructions, however, summary plan descriptions (SPDs) are not used in the individual market, in which case "policy document" should be referenced instead. Second, the Subgroup suggests that flexibility to cross-reference language located in the SPD "or other applicable documents" would be appropriate in this context, and could mirror language found in the instructions for "Special Rule for 3.a. Core limitations, exceptions, and other important information," which says:

> [F]or each set of limitations or exceptions that cannot be fully described, the plan or issuer should cross reference the pages or identify the sections where the limitations and exceptions are described in the applicable document that fully describes the limitations and exceptions, such as the relevant pages of the summary plan description or policy document.

IV. Revise Instruction for "Embedded Deductible"

- The instructions are not clear enough for describing family coverage with an embedded deductible in the "Why This Matters" column of the important question "What is the Overall Deductible?" The current language says: "If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible has been met." The Subgroup suggests the following language to better explain this difficult topic:

> Generally, the plan will only begin to pay its share of the cost of covered services that an individual family member receives once that family member's individual deductible has been met. Other family members must pay the full cost of covered services until they meet their own individual deductible or until the total amount of deductible expenses paid by family members meets the overall family deductible.

V. Need Additional Instruction For "Why This Matters" Column of the Important Question "Are There Services Covered Before You Meet Your Deductible?"

- The Subgroup suggests adding the following optional language to the individual and group instructions for the "Why this matters" column of the important question "Are there services covered before you meet your deductible?" to address HSA plans and similarly configured plans that apply a deductible to all services (except preventive): "You must meet the deductible for all services, except preventive services, unless stated as 'no charge' and then any applicable copayment or coinsurance may apply."

VI. Re-Consider Location for Deductible Limitation Information

- The February 2016 instructions changed the location for the inclusion of information about separate deductibles or services covered at no cost. The information is to be represented in the "what you will pay" column instead of the "limitations exceptions and other important information" column, where it was previously located. The Subgroup would like the Tri-Agencies to, at a minimum: 1) highlight the new location for this information for plans and issuers, so there is no confusion and ensure consistent placement between plans; or 2) consider going back to including that information in the "limitations exceptions and other important information" column, which is wider and has more room for plans and issuers to include additional information.

VII. Clarification Needed for Instructions for "Services You May Need" Column Under Common Medical Event: "If You Need Drugs to Treat Your Illness or Condition"

- The "Specific Additional Instructions for Some of the Common Medical Events" for the "services you may need" column under "If you need drugs to treat your illness or condition" are problematic for plans that have tier designs that do no correlate with the categories listed in the instructions: "Generic drugs", "Preferred brand drugs", "Non-preferred brand drugs", and "Specialty drugs". For example, some plan designs include classes of drugs that may appear in more than one tier and the instructions do not provide clear guidance for these situations. This was an issue identified by the Subgroup, and was addressed in our October submission by requiring the plan or issuer to list the category of prescription drug coverage using the same terminology used in the formulary, in the policy or plan document and on the website, and after, include a parenthetical giving context to the category of drugs in terms of its cost to the consumer (e.g., these drugs will cost the least, more or the most). We urge the Tri-Agencies to reconsider our earlier recommendation or to provide more specific guidance.

VIII. Issues in the "Excluded Services" or "Other Covered Services" Boxes.

- The Tri-Agencies should consider allowing plans and issuers flexibility to cross-reference language located in the SPD or other applicable document in this context, and could mirror language found in the instructions for "Special Rule for 3.a. Core limitations, exceptions, and other important information."

- Column-based alphabetizing was replaced with row-based alphabetizing in these boxes. The current format with column-based alphabetizing should be retained so plans and issuers do not incur unnecessary re-programming costs.

- The group and individual instructions require the use of the term "abortion", however, industry representatives indicate the Office of Personnel Management requires use the of the term "termination of pregnancy". Guidance is requested.

IX. Concern with Duplicative Information in the "Your Rights to Continue Coverage" Section and the "Your Grievance and Appeals Rights"

- The same contact information could be listed under both the "Your Rights to Continue Coverage" and the "Your Grievance and Appeals Rights" sections, which is unnecessary duplication, particularly in light of the page limitation. These two items could be combined when they are the same. Guidance is requested.

X. Need Additional Instruction for Communicating SBC to People with Disabilities

- While the individual and group instructions appropriately reference the need for language access services and the obligation to provide the SBC in a culturally and linguistically appropriate manner, nothing addresses providing the SBC to people with disabilities in alternate formats such as Braille, large print and electronic disc. There are also potentially software or web designs that could be implemented to address accessibility issues. This was not something explored by the Subgroup; however, it is a very worthwhile topic the Tri-Agencies should consider and investigate in future updates.

XI. Special Instructions for Coverage Examples

- The Subgroup's insurer representatives noted that the instructions for the coverage examples do not allow plans to vary the list of "The plan's overall deductible", "Specialist copayment", "Hospital (facility) coinsurance" and "Other coinsurance", which could be problematic for plans with different cost-sharing arrangements. For example, plans may have a specialist coinsurance not a copayment. The Tri-Agencies should include instructions for plans to include the appropriate deductible, copayment and coinsurance charges to accurately reflect the plan.

XII. Inconsistencies in the Uniform Glossary

- There are inconsistencies in commas, hyphenation, and capitalization, some of which affect readability. The attached document contains revisions to the Uniform Glossary to follow the rules that: 1) a comma is used after the next-to-the-last item in a list; 2) cost sharing is hyphenated when it's an adjective but not when it's a noun; and 3) the first letter of each word in a hyphenated term is capitalized when it's a heading. In addition, punctuation was moved outside quotation marks where it was otherwise to be consistent throughout. In addition, the term being defined should not be underlined in that term's definition as it is in Out-of-Network Coinsurance. Readability revisions were made to definition of "minimum value standard." Please note that this change has to carry over to the group and individual instructions to be included in the SBC.

XIII. Issues in Posted Documents

- In the Group and Individual Instructions, under "General Instructions" under "Special Rule," plans and issuers are instructed to underline terms in the SBC that are defined in the Uniform Glossary. There are inconsistencies with the underlining of defined terms in the sample SBC templates released for comment. Although plans and issuers will be responsible for creating the actual SBCs, the examples serve as a model and should be corrected.

- The following statement appears several times in the example SBC: "Preauthorization is required. Failure to obtain preauthorization may result in a reduction in benefits by 50% of the total cost of the service." While we recognize that this is not mandated language, it violates readability principles, and to the extent the sample SBC serves as an example for plans and issuers, more readable language should be used. A more readable version is: "Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service."

- The Coverage Examples are presented with cost sharing that assumes an enrollee does not participate in a wellness program, and include a note to consumers stating, "Note: These numbers assume the patient does not participate in the plan's wellness program." However, the Proposed Guide for Coverage Examples Calculations lists as a standard assumption the following: "If the plan has a wellness program that varies the deductibles, copayments, coinsurance, or coverage for any of the services listed in a

treatment scenario, the plan must complete the calculations for that treatment scenario assuming that the patient is participating in the wellness program." This assumption should be updated to be consistent with the treatment of cost sharing for the Coverage Examples.

- The sample Coverage Examples provide for a $500 overall deductible, but the deductible paid is $800 for Joe and $700 for Mia. It is unclear whether the extra deductibles are from specific deductibles, but at a minimum we wanted to point to this area of potential confusion. The Tri-Agencies should remain mindful of the potential for confusion in this area and consider whether specific deductibles should be eliminated from the calculation for the examples, so the numbers make more sense.

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 ~~such~~ 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

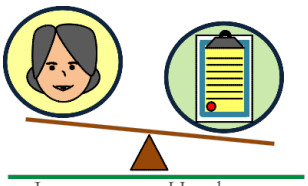
When a provider bills you for the balance remaining on the bill that ~~is not covered by~~ your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. This happens most often when you see an out-of-network provider (non-preferred provider). A preferred provider may not bill you for covered services.

Claim

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

Coinsurance

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



(See page 6 for a detailed example.)

Complications of Pregnancy

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

Copayment

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

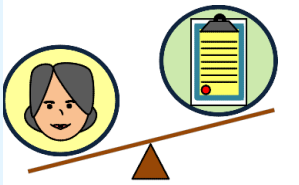
Cost Sharing

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

Cost-sharing Reductions

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

Deductible



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

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

Diagnostic Test

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

Durable Medical Equipment (DME)

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

Emergency Medical Condition

An illness, injury, symptom (including severe pain) or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following ~~to result~~: 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 ~~place~~ put drugs in~~at~~ 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 ~~does not~~doesn't include help with non-medical tasks, such as cooking, cleaning or driving.

Hospice Services

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

Hospitalization

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

Hospital Outpatient Care

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

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

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

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

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

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

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

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

Minimum Value Standard
A basic standard ~~for~~ to measur~~ing~~ the percent~~age~~ of permitted costs ~~covered by~~ 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, ~~and~~ artificial legs, arms, and eyes, and external breast prostheses ~~incident to~~after a mastectomy resulting from breast cancer. 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 ~~do not~~don't contract with your health insurance or plan. Out-of- network coinsurance usually costs you more than in- network coinsurance.

Comment [CJR1]: do not underline term in its own definition.

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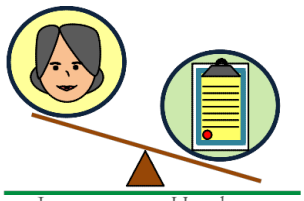
Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

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-particiapting" instead of "out-of-network provider".

Out-of-pocket Limit



(See page 6 for a detailed example.)

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

Physician Services

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

Plan

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

Preauthorization

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

Premium

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

Premium Tax Credits

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

Prescription Drug Coverage

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

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care

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. A non-physician specialist is a provider who has special training in a specific area of health care.

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

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

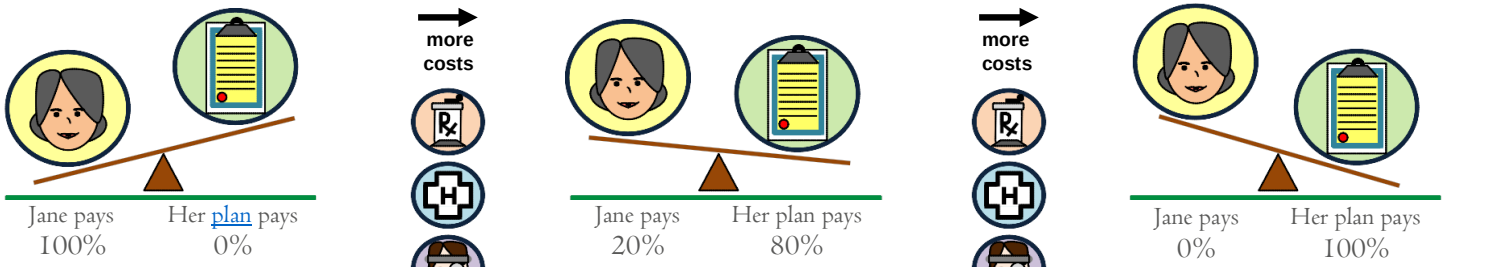
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

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

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



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

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

Jane reaches her $5,000 out-of-pocket limit
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $125
Jane pays: $0
Her plan pays: $125