**Gold EPO HSA Val 80%/80%**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

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<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>For participating providers $1,300 person*/$2,600 family. Deductible may not apply to all services. *Per person deductible not applicable in policies covering 2 or more people.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don't have to meet <strong>deductibles</strong> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>Yes. For participating providers $2,600 person / $5,200 family.</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, out-of-network balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain precertification for services.</td>
<td>Even though you pay these expenses, they don't count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td><strong>Is there an overall annual limit on what the plan pays?</strong></td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. See <a href="http://www.amerihealthnj.com/provider_finder">www.amerihealthnj.com/provider_finder</a> or call 1-888-YOUR-AH1 (TTY:711) for a list of participating providers.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>No. You don't need a referral to see a specialist.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td><strong>Are there services this plan doesn't cover?</strong></td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed in the Excluded Services &amp; Other Covered Services section. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

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**Questions:** Call 1-888-YOUR-AH1 (TTY:711) or visit us at [www.amerihealthnj.com](http://www.amerihealthnj.com). If you aren’t clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at [www.amerihealthnj.com](http://www.amerihealthnj.com) or call 1-888-YOUR-AH1 (TTY:711) to request a copy.
- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the *allowed amount* for the service. For example, if the plan’s *allowed amount* for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven’t met your deductible.
- The amount the plan pays for covered services is based on the *allowed amount*. If an out-of-network provider charges more than the *allowed amount*, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the *allowed amount* is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>20%, after Deductible (ded)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>20%, after ded</td>
<td>Not Covered. Therapeutic manipulations: 30 visits per calendar year.</td>
</tr>
<tr>
<td>Preventive care / screening / immunization</td>
<td>No Charge, no ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20%, after ded(X-Ray)/No Charge, after ded(Blood Work)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$7 Copayment (copay), after ded (1-30 days supply/Retail &amp; Mail); $14 copay, after ded (31-90/ Mail), per prescription fill</td>
<td>Not Covered. Prior authorization may be required on some drugs. Covers up to a 90 day supply.</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>50%, after ded (1-30 days supply/Retail &amp; Mail) Maximum (max) $125; 50%, after ded (31-90/ Mail) max $250, per prescription fill</td>
<td>Not Covered. Prior authorization may be required on some drugs. Covers up to a 90 day supply.</td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>50%, after ded (1-30 days supply/Retail &amp; Mail) max $125; 50%, after ded (31-90/ Mail) max $250, per prescription fill</td>
<td>Not Covered. Prior authorization may be required on some drugs. Covers up to a 90 day supply.</td>
</tr>
</tbody>
</table>

More information about [prescription drug coverage](#) is available at [www.amerihealthnj.com/formulary](http://www.amerihealthnj.com/formulary).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>an In-Network Provider</td>
<td>an Out-Of Network Provider</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>50%, after ded (1-30 days supply/ Retail &amp; Mail) max $125; 50%, after ded (31-90/ Mail) max $250, per prescription fill</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialty Drugs which are covered under the Prescription Drug Plan. Covers up to a 90 day supply. Prior authorization and/or dispensing limits may apply. Other Specialty Drugs and infusion therapy drugs may be covered under your medical benefits plan as stated within your Policy and/or Drug Rider information. A complete list of drugs requiring Prior authorization is available at <a href="http://www.americanhealthnj.com/precert">www.americanhealthnj.com/precert</a>.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>20%, after ded</td>
<td>Covered at in-network level</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20%, after ded</td>
<td>Covered at in-network level</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20%, after ded</td>
<td>Covered at in-network level</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Substance abuse disorder outpatient services</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Substance abuse disorder inpatient services</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No Charge, no ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20%, after ded</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic Surgery
- Dental care (adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine Eye care (adult)
- Routine foot care
- Weight loss programs

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

- Abortion, in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids (covered for members age 15 and younger)
- Infertility Treatment (limited to artificial insemination; requires pre approval)
- Private-duty nursing (covered under Home Health Care)
- Acupuncture
- Cosmetic Surgery

### Common Medical Event

#### Services You May Need

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Cost</th>
<th>Out-Of-Network Cost</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habilitation services</td>
<td>20%, after ded</td>
<td>Not Covered</td>
<td>Physical, Occupational, Speech and Cognitive therapies: 30 visits each per calendar year. Visit limits do not apply for Treatment of Autism.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20%, after ded</td>
<td>Not Covered</td>
<td>Prior authorization is required.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>50%, after ded</td>
<td>Not Covered</td>
<td>Prior authorization is required for selected items.</td>
</tr>
<tr>
<td>Hospice service</td>
<td>20%, after ded</td>
<td>Not Covered</td>
<td>Prior authorization is required.</td>
</tr>
<tr>
<td>Eye exam</td>
<td>No Charge, no ded</td>
<td>Not Covered</td>
<td>Pediatric Vision; Once every calendar year.</td>
</tr>
<tr>
<td>Glasses</td>
<td>No Charge, no ded</td>
<td>Not Covered</td>
<td>Pediatric Vision; Once every calendar year.</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>------------------none----------------</td>
</tr>
</tbody>
</table>

### Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact us at 888-YOUR-AH1 (TTY:711) or contact the New Jersey Department of Banking and
Insurance at 800-446-7467.

Your Grievance and Appeals Rights:
If you are dissatisfied with a denial of coverage for claims under your plan, you may contact AmeriHealth NJ at 1-877-585-5731 (TTY:711). As an alternative, the New Jersey Department of Banking and Insurance can also provide assistance. Please contact them via the Internet: http://www.state.nj.us/dobi/consumer.htm, by email: ombudsman@dobi.state.nj.us, or by telephone: 1-888-393-1062.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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

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

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

See the next page for important information about these examples.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan Pays</strong> $5,190</td>
<td><strong>Plan Pays</strong> $3,170</td>
</tr>
<tr>
<td><strong>Patient Pays</strong> $2,350</td>
<td><strong>Patient Pays</strong> $2,230</td>
</tr>
</tbody>
</table>

**Sample Care Costs:**

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

**Total**: $7,540

**Patient Pays**

- **Deductibles**: $1,300
- **Copays**: $10
- **Coinsurance**: $890
- **Limits or exclusions**: $150

**Total**: $2,350

**Sample Care Costs:**

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

**Total**: $5,400

**Patient Pays**

- **Deductibles**: $1,300
- **Copays**: $80
- **Coinsurance**: $770
- **Limits or exclusions**: $80

**Total**: $2,230
Questions and answers about the Coverage Examples:

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

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

Does the Coverage Example predict my own care needs?
- No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?
- No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
- Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

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

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You can view the Glossary at www.amerihealthnj.com or call 1-888-YOUR-AH1 (TTY:711) to request a copy.
Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn’t a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. 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.)

- **Bold blue** text indicates a term defined in this Glossary.

- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

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**Allowed Amount**

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

**Appeal**

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

**Balance Billing**

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

**Co-insurance**

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance plus any **deductibles** you owe. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your co-insurance payment of 20% would be $20. The health 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 aren’t complications of pregnancy.

**Co-payment**

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

**Deductible**

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

**Durable Medical Equipment (DME)**

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

**Emergency Medical Condition**

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

**Emergency Medical Transportation**

Ambulance services for an emergency medical condition.

**Emergency Room Care**

**Emergency services** you get in an emergency room.

**Emergency Services**

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
Excluded Services
Health care services that your health insurance or plan doesn’t pay for or cover.

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 your health insurer to pay some or all of your health care costs in exchange for a premium.

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

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

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

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

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

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

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

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

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

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

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

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

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.
Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health 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.

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

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

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

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

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

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

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

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

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

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

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

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

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.
How You and Your Insurer Share Costs - Example

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

January 1st  
Beginning of Coverage Period

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

more costs

Jane reaches her $1,500 deductible, co-insurance begins  
Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.
  Office visit costs: $75  
  Jane pays: 20% of $75 = $15  
  Her plan pays: 80% of $75 = $60

more costs

December 31st  
End of Coverage Period

Jane reaches her $5,000 out-of-pocket limit  
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
  Office visit costs: $200  
  Jane pays: $0  
  Her plan pays: $200

more costs

Jane pays  
Her plan pays

100%  
0%
Language Assistance Services


Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。


Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.


Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете использовать бесплатные услуги перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متوفرة لك بالمجانية. اتصل برقم 275-2583.


Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।


Japanese: 備考: 母国語が日本語の方は、言語アシスタントサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi): توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می گردد. با شماره 1-800-275-2583 تماس بگیرید.


Urdu: توجیه: اگر آپ اردو زبان بولتے ہیں تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583。

Mon-Khmer, Cambodian: សូមេម័ជាពិសេសសិនេបើអនកនិយយភ័ែខមរឬភ័ែខមរនះជំនួយែផនកភ័យចុនដល់េǎកអនកេƽយឥតគិតថ្ល។ ទូរសពទេទេលខ 1-800-275-2583។
Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.