# Schedule of Benefits

## AmeriHealth Caritas Next Silver Essential 73 + Two free PCP Visits + Free 24/7 Preferred Provider PCP/Urgent Virtual Care + No Referrals

Benefit period: From 01/01/2027 through 12/31/2027 Calendar Year.

# About your Schedule of Benefits

This Schedule of Benefits outlines services that may be covered under your health benefit plan. Please refer to the Evidence of Coverage (EOC) document for more details on covered health services and important limitations. Your EOC also describes preventive services covered with no cost-sharing. As a member, you are responsible for the deductible, copayments, and coinsurance for eligible services.

## Coinsurance

A percentage of the allowed amount you are required to pay for covered health services and prescription drugs, for example 20%. A copayment is not a coinsurance.

## Copayment

A specific dollar amount you may be required to pay as your share of the allowed amount for covered health services or prescription drugs you receive. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug. A copayment is not a coinsurance.

## Deductible

The amount you must pay for covered health services or prescription drugs each year before the health benefit plan begins to pay.

## Limitations and Exclusions

Some benefit limitations and exclusions are outlined on p. 3-7 below. Please review your EOC and other policy documents. These give a full description of services and items that are limited or not covered by your health benefit plan.

## Out-of-Pocket Maximum

The most that you pay out-of-pocket during the calendar year for in-network covered health services. It includes deductibles and any cost-sharing amounts the member has paid. Amounts you pay for premiums do not count toward the out-of-pocket maximum amount.

## Quantity Limits

A tool to limit the use of selected drugs for quality, safety, or utilization reasons. Drugs may be limited by the amount that we cover per prescription or for a defined period of time.

## Prior Authorization

Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from your health benefit plan.

**Note:**

AmeriHealth Caritas Next plans do not offer embedded pediatric dental coverage as there are stand-alone pediatric dental plans available in the exchange for purchase. AmeriHealth Caritas Next will inform consumers of the availability of stand-alone pediatric dental plans during the plan selection and enrollment process.

# Your Deductible and Out-of-Pocket Maximum

This Benefit Overview describes your coverage and Cost Sharing Amounts, including Deductible and Out-of-Pocket Maximum, under this plan.

| General Cost Share & Features | In Network | Out of Network |
|---|---|---|
| **Deductible:**<br>- Per Calendar Year<br>- Medical and Drug Combined<br>- Some services do not apply to the deductible, as indicated below. | $3,600/Individual<br>$7,200/Family | Not Covered |
| **Out-of-Pocket Maximum:**<br>- Per Calendar Year<br>- Medical and Drug Combined | $9,600/Individual<br>$19,200/Family | Not Covered |

If you are the subscriber, and the only member covered under your health benefit plan, the individual out-of-pocket maximum amount applies. If you have other family members on your plan, the family out-of-pocket maximum amount applies. The plan has an embedded individual out-of-pocket maximum within the family out-of-pocket maximum. No one member can contribute more than their individual out-of-pocket maximum amount to the family out-of-pocket maximum. Copayment or coinsurance amounts a member pays for services shown as covered without an out-of-pocket maximum will not count toward meeting the individual or family out-of-pocket maximum.

# Benefit Details

The following table provides basic information about your benefits under this plan.

| Benefit | In Network | Out of Network |
|---|---|---|
| **Primary & Specialist Office Visits** | | |
| Primary Care Visit to Treat an Injury or Illness | From 1 to 2 Visit - No Charge<br>Visit 3 and after - $30 Copayment per visit | Not Covered |
| Specialist Visit | $100 Copay per visit | Not Covered |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | $30 Copay per visit | Not Covered |
| Routine Foot Care | $100 Copay per visit | Not Covered |
| Virtual Care 24/7<br>*Virtual care visits offered through AmeriHealth Caritas Next Virtual Care 24/7 are covered at No Charge; your deductible does not apply. Otherwise, virtual care visits are subject to the same cost sharing responsibilities as office visits.* | No Charge | Not Covered |
| **Preventive Care** | | |
| Newborn Hearing Screening | No Charge | Not Covered |
| Nutritional Counseling | No Charge | Not Covered |
| Preventive Care/Screening/Immunization | No Charge | Not Covered |
| Well Baby Visits and Care | No Charge | Not Covered |

| Benefit | In Network | Out of Network |
|---|---|---|
| **Therapy** | | |
| Chiropractic Care<br>*Up to 30 visits per benefit period; Up to 3 modalities per visit; maximum of one visit per day. Visits for the treatment of the spine and other neuromusculoskeletal structures, including extremities, are not subject to these limits.* | $100 Copay per visit | Not Covered |
| Habilitation Services†<br>*Combined limit of 30 visits per benefit period for Habilitative Physical Therapy and Occupational Therapy; 30 visits per benefit period for Habilitative Speech Therapy. Physical therapy visits for the treatment of the spine and other neuromusculoskeletal structures, including extremities, are not subject to these limits.* | Deductible, then 35% Coinsurance | Not Covered |
| Outpatient Rehabilitation Services†<br>*Combined limit of 30 visits per benefit period for Rehabilitative Physical Therapy and Occupational Therapy; 30 visits per benefit period for Rehabilitative Speech Therapy. Physical therapy visits for the treatment of the spine and other neuromusculoskeletal structures, including extremities, are not subject to these limits.* | Deductible, then 35% Coinsurance | Not Covered |
| Rehabilitative Occupational and Rehabilitative Physical Therapy†<br>*Combined limit of 30 visits per benefit period for Rehabilitative Physical Therapy and Occupational Therapy. Physical therapy visits for the treatment of the spine and other neuromusculoskeletal structures, including extremities, are not subject to these limits.* | Deductible, then 35% Coinsurance | Not Covered |
| Rehabilitative Speech Therapy†<br>*30 visits per benefit period* | Deductible, then 35% Coinsurance | Not Covered |
| Infusion Therapy† | Deductible, then 35% Coinsurance | Not Covered |
| Chemotherapy† | Deductible, then 35% Coinsurance | Not Covered |
| Radiation | Deductible, then 35% Coinsurance | Not Covered |
| **Diagnostic & Imaging** | | |
| Imaging (CT/PET Scans, MRIs)† | Deductible, then 35% Coinsurance | Not Covered |
| Laboratory Outpatient and Professional Services† | Deductible, then 35% Coinsurance | Not Covered |
| X-rays and Diagnostic Imaging | Deductible, then 35% Coinsurance | Not Covered |
| **Outpatient Care** | | |
| Mental/Behavioral Health Office Visits | From 1 to 2 Visit - No Charge<br>Visit 3 and after - $30 Copayment per visit | Not Covered |

| Benefit | In Network | Out of Network |
|---|---|---|
| Mental/Behavioral Health Outpatient Services† | Deductible, then 35% Coinsurance | Not Covered |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)† | Deductible, then 35% Coinsurance | Not Covered |
| Outpatient Surgery Physician/Surgical Services† | Deductible, then 35% Coinsurance | Not Covered |
| Substance Abuse Disorder Office Visits | From 1 to 2 Visit - No Charge<br>Visit 3 and after - $30 Copayment per visit | Not Covered |
| Substance Abuse Disorder Outpatient Services† | Deductible, then 35% Coinsurance | Not Covered |
| **Inpatient Care** | | |
| Childbirth/Delivery Facility Services† | Deductible, then 35% Coinsurance | Not Covered |
| Coronary Artery Bypass Graft† | Deductible, then 35% Coinsurance | Not Covered |
| Inpatient Hospital Services (e.g., Hospital Stay)† | Deductible, then 35% Coinsurance | Not Covered |
| Inpatient Physician and Surgical Services† | Deductible, then 35% Coinsurance | Not Covered |
| Mental/Behavioral Health Inpatient Services† | Deductible, then 35% Coinsurance | Not Covered |
| Skilled Nursing Facility†<br>*120 days per admission* | Deductible, then 35% Coinsurance | Not Covered |
| Substance Abuse Disorder Inpatient Services† | Deductible, then 35% Coinsurance | Not Covered |
| **Hospice Care** | | |
| Hospice Services† | Deductible, then No Charge | Not Covered |
| **Home Health Care, Nursing Home Care, and Private Duty Nursing** | | |
| Home Health Care Services†<br>*100 visits per benefit period* | Deductible, then 35% Coinsurance | Not Covered |
| Long-Term/Custodial Nursing Home Care | Not Covered | Not Covered |
| Private-Duty Nursing†<br>*240 hours per benefit period* | Deductible, then 35% Coinsurance | Not Covered |
| **Urgent Care** | | |
| Urgent Care Centers or Facilities | $150 Copay per visit | |
| **Emergency Care/Ambulance** | | |
| Emergency Room Services | Deductible, then 35% Coinsurance | |
| Emergency Transportation/Ambulance | Deductible, then 35% Coinsurance | |
| **Durable Medical Equipment and Devices** | | |
| Durable Medical Equipment† | Deductible, then 50% Coinsurance | Not Covered |
| Prosthetic Devices† | Deductible, then 50% Coinsurance | Not Covered |
| **Dental Care** | | |
| Accidental Dental† | Deductible, then 35% Coinsurance | Not Covered |

| Benefit | In Network | Out of Network |
|---|---|---|
| Basic Dental Care – Child | Not Covered | Not Covered |
| Basic Dental Care – Adult | Not Covered | Not Covered |
| Dental Check-Up for Children | Not Covered | Not Covered |
| Dental Services for Children with Severe Disabilities† | Deductible, then 35% Coinsurance | Not Covered |
| Major Dental Care – Child | Not Covered | Not Covered |
| Major Dental Care – Adult | Not Covered | Not Covered |
| Orthodontia – Child | Not Covered | Not Covered |
| Orthodontia – Adult | Not Covered | Not Covered |
| Routine Dental Services (Adult) | Not Covered | Not Covered |
| **Pediatric Vision Services**<br>**Covered through the last day of the month in which a child turns 19** | | |
| Contact Lenses for Children<br>*1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period* | No Charge | Not Covered |
| Eye Glasses for Children<br>*1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period* | No Charge | Not Covered |
| Low Vision Exams and Aids for Children†<br>*1 exam per 5 years* | Deductible, then 35% Coinsurance | Not Covered |
| Routine Eye Exam for Children<br>*1 exam per benefit period* | No Charge | Not Covered |
| **Additional Services** | | |
| Abortion<br>*750 dollars per year* | No Charge | Not Covered |
| Acupuncture | Not Covered | Not Covered |
| Allergy Testing | $100 Copay per visit | Not Covered |
| Autism Spectrum Disorders (ASD)† | Deductible, then 35% Coinsurance | Not Covered |
| Bariatric Surgery†<br>*1 procedures per lifetime* | Deductible, then 50% Coinsurance | Not Covered |
| Cancer Monitoring Test | Deductible, then 35% Coinsurance | Not Covered |
| Cardiac Rehabilitation†<br>*30 visits per benefit period* | Deductible, then 35% Coinsurance | Not Covered |
| Clinical Trials† | Deductible, then 35% Coinsurance | Not Covered |
| Cosmetic Surgery | Not Covered | Not Covered |
| Diabetes Care Management | Deductible, then 35% Coinsurance | Not Covered |
| Diabetes Education | No Charge | Not Covered |

| Benefit | In Network | Out of Network |
|---|---|---|
| Dialysis | Deductible, then 35% Coinsurance | Not Covered |
| Doula† | $100 Copay per visit | Not Covered |
| Hearing Aids†<br>*1 wearable item per impaired ear per 3 years* | Deductible, then 35% Coinsurance | Not Covered |
| Infertility Treatment†<br>*6 procedures per lifetime* | Deductible, then 35% Coinsurance | Not Covered |
| Inherited Metabolic Disorder - PKU† | Deductible, then 35% Coinsurance | Not Covered |
| Routine Prenatal and Postnatal Care | No Charge | Not Covered |
| Pulmonary Rehabilitation†<br>*36 treatments per benefit period* | Deductible, then 35% Coinsurance | Not Covered |
| Reconstructive Surgery† | Deductible, then 35% Coinsurance | Not Covered |
| Routine Eye Exam (Adult) | Not Covered | Not Covered |
| Reversible Contraceptives | Deductible, then 35% Coinsurance | Not Covered |
| School Based Health Centers | Deductible, then 35% Coinsurance | Not Covered |
| Transplant† | Deductible, then 35% Coinsurance | Not Covered |
| Treatment for Temporomandibular Joint Disorders† | Deductible, then 50% Coinsurance | Not Covered |
| Weight Loss Programs | Not Covered | Not Covered |

† Prior authorization may be required

# Prescription Drugs

**Prescription Deductible and Out-of-Pocket Maximum (OOPM)**

| Prescription Cost Share & Features | In Network | Out of Network |
|---|---|---|
| Deductible<br>(Integrated with Medical Deductible) | $3,600/Individual<br>$7,200/Family | Not Covered |
| Out of Pocket Maximum<br>(Integrated with Medical Out of Pocket Maximum) | $9,600/Individual<br>$19,200/Family | Not Covered |

| Retail Pharmacy (per 30 day supply) | | |
|---|---|---|
| **Tier** | **In Network** | **Out of Network** |
| Preferred Generic Drugs (Tier 1a) | $5 Copay per prescription | Not Covered |
| Non-Preferred Generic Drugs (Tier 1b) | $25 Copay per prescription | Not Covered |
| Preferred Brand Drugs (Tier 2) | $60 Copay per prescription | Not Covered |
| Non-Preferred Brand and Non-Preferred (High Cost) Generic Drugs (Tier 3) | Deductible, then $110 Copay per prescription | Not Covered |
| Specialty Drugs (Tier 4a) | Deductible, then $120 Copay per prescription | Not Covered |
| Non-Preferred Specialty Drugs (Tier 4b) | Deductible, then $150 Copay per prescription | Not Covered |

Prescription Drug Notes:

1. Covers up to a 90-day supply for retail and mail order prescriptions.
2. Cost-share shown is per retail prescription per 30-day supply. Mail order cost-share is the same as retail prescription. Mail order and retail cost-share is 1 copayment for a 1-30 day supply, 2 copayments for a 31-60 day supply, and 3 copayments for a 61-90 day supply.
3. Prior authorization / step therapy may be required.

AmeriHealth Caritas Next

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby. jsf** or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building Washington, DC 20201, phone: **1-800-368-1019**, **TTY: 1-800-537-7697**. Complaint forms are available at **https://www. hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf**.

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## We speak your language

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