



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, call 1-844-350-2177 (TTY 711). For general 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.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-844-350-2177 (TTY 711) to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | In Network: \$2,500/Individual, \$5,000/Family<br>Out of Network: Not Covered                                                                                                                                                                                                                                                                                                                                                                                                                                               | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> 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> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care/screening</a> /immunization, children's eye exam and glasses, Primary Care, <a href="#">Specialist</a> Care, <a href="#">Urgent Care</a> , <a href="#">Rehabilitation</a> , <a href="#">Habilitation services</a> , <a href="#">Mental/Behavioral Health Office Visits</a> , Preferred generic drugs (Tier 1), Preferred brand drugs (Tier 2), Office visits for routine pregnancy, and <a href="#">Substance Abuse Office Visits</a> do not apply toward the <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet 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 <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | In Network: \$8,600/Individual, \$17,200/Family<br>Out of Network: Not Covered                                                                                                                                                                                                                                                                                                                                                                                                                                              | 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 limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                              |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">preauthorization</a> for services and health care this <a href="#">plan</a> does not cover.                                                                                                                                                                                                                                                                                                                 | Even though you pay these expenses they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.amerithealthcaritasnext.com/oh/">www.amerithealthcaritasnext.com/oh/</a> or call 1-844-350-2177(TTY 711) for a list of <a href="#">network providers</a> .                                                                                                                                                                                                                                                                                                                                     | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . 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. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



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                                        | What You Will Pay                                                                       |                                               | Limitations, Exceptions, & Other Important Information                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                     |                                                              | In Network<br>(You will pay the least)                                                  | Out of Network<br>(You will pay the most)     |                                                                                                                                                                                                                             |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                                                                                              | Primary care visit to treat an injury or illness.            | \$30 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply        | Not Covered                                   | None                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                     | <a href="#">Specialist</a> visit                             | \$60 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply        | Not Covered                                   | None                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                     | <a href="#">Preventive care/screening</a> /immunization      | No Charge, <a href="#">Deductible</a> does not apply                                    | Not Covered                                   | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                                                                                                                                                                                                                                  | <a href="#">Diagnostic test</a> (x-ray, blood work)          | X-ray: 25% <a href="#">coinsurance</a><br>Blood work: 25% <a href="#">coinsurance</a>   | X-ray: Not Covered<br>Blood work: Not Covered | None.                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                     | Imaging (CT/PET scans, MRIs)                                 | 25% <a href="#">coinsurance</a>                                                         | Not Covered                                   | Prior authorization may be required.<br>Covered no limit.                                                                                                                                                                   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://welcome.benefitrx.com/acnextoh/prescription-drug-list">https://welcome.benefitrx.com/acnextoh/prescription-drug-list</a> | Preferred generic drugs (Tier 1)                             | \$15 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply | Not Covered                                   |                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                     | Preferred brand drugs (Tier 2)                               | \$30 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply | Not Covered                                   |                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                     | Non-preferred brand and non-preferred generic drugs (Tier 3) | \$60 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply | Not Covered                                   |                                                                                                                                                                                                                             |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.amerihealthcaritasnext.com/content/dam/amerihealth-caritas/acnext/pdf/oh/2027/member/forms/evidence-of-coverage.pdf.coredownload.inline.pdf>

| Common Medical Event                    | Services You May Need                            | What You Will Pay                                                                        |                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                           |
|-----------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                  | In Network<br>(You will pay the least)                                                   | Out of Network<br>(You will pay the most) |                                                                                                                                                                                                                                                  |
|                                         | <a href="#">Specialty drugs</a> (Tier 4)         | \$250 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply | Not Covered                               | Prior authorization / step therapy may be required. Covers up to a 30-day supply (retail subscription); 31–90 day supply (mail order prescription). Cost share shown is per retail prescription. Mail order cost share is 2.5 times retail cost. |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | 25% <a href="#">coinsurance</a>                                                          | Not Covered                               | Prior authorization may be required. Covered no limit.                                                                                                                                                                                           |
|                                         | Physician/surgeon fees                           | 25% <a href="#">coinsurance</a>                                                          | Not Covered                               | Prior authorization may be required. Covered no limit.                                                                                                                                                                                           |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | 25% <a href="#">coinsurance</a>                                                          | 25% <a href="#">coinsurance</a>           | You pay the same level as in-network if it is an emergency as defined in your policy, otherwise not covered.                                                                                                                                     |
|                                         | <a href="#">Emergency medical transportation</a> | 25% <a href="#">coinsurance</a>                                                          | 25% <a href="#">coinsurance</a>           | None                                                                                                                                                                                                                                             |

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| Common Medical Event                                                      | Services You May Need              | What You Will Pay                                                                                                                                              |                                                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                    |
|---------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                    | In Network<br>(You will pay the least)                                                                                                                         | Out of Network<br>(You will pay the most)                                        |                                                                                                                                                                                                                                                                           |
|                                                                           | <a href="#">Urgent care</a>        | \$45 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply                                                                               | \$45 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply | Out-of-network <a href="#">Urgent Care</a> services are covered when <a href="#">network providers</a> are temporarily unavailable or inaccessible and if the services are for an urgent condition as defined in your <a href="#">plan</a> policy, otherwise not covered. |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room) | 25% <a href="#">coinsurance</a>                                                                                                                                | Not Covered                                                                      | Prior authorization may be required. Covered no limit.                                                                                                                                                                                                                    |
|                                                                           | Physician/surgeon fees             | 25% <a href="#">coinsurance</a>                                                                                                                                | Not Covered                                                                      | Prior authorization may be required. Covered no limit.                                                                                                                                                                                                                    |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                | \$30 <a href="#">copayment</a> /office visit , <a href="#">Deductible</a> does not apply<br><br>25% <a href="#">coinsurance</a> for other outpatient services. | Not Covered                                                                      | Covered no limit. The cost sharing that displays next to office visit, applies to outpatient office visits only. All other outpatient services may be subject to additional cost sharing. Please refer to the plan policy documents for detailed information.             |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.amerihealthcaritasnext.com/content/dam/amerihealth-caritas/acnext/pdf/oh/2027/member/forms/evidence-of-coverage.pdf.coredownload.inline.pdf>

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                                |                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                            |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | In Network<br>(You will pay the least)                                           | Out of Network<br>(You will pay the most) |                                                                                                                                                                                                                                                                   |
|                                                                | Inpatient services                        | 25% <a href="#">coinsurance</a>                                                  | Not Covered                               | Prior authorization may be required.<br>Covered no limit.                                                                                                                                                                                                         |
| If you are pregnant                                            | Office visits                             | No Charge, <a href="#">Deductible</a> does not apply                             | Not Covered                               | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                | Childbirth/delivery professional services | 25% <a href="#">coinsurance</a>                                                  | Not Covered                               |                                                                                                                                                                                                                                                                   |
|                                                                | Childbirth/delivery facility services     | 25% <a href="#">coinsurance</a>                                                  | Not Covered                               |                                                                                                                                                                                                                                                                   |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 25% <a href="#">coinsurance</a>                                                  | Not Covered                               | 100 visits per benefit period<br>Prior authorization may be required.                                                                                                                                                                                             |
|                                                                | <a href="#">Rehabilitation services</a>   | \$30 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply | Not Covered                               | Combined limit of 60 visits per benefit period for all outpatient therapy<br>Prior authorization may be required.                                                                                                                                                 |
|                                                                | <a href="#">Habilitation services</a>     | \$30 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply | Not Covered                               | Prior authorization may be required.<br>Covered no limit.                                                                                                                                                                                                         |
|                                                                | <a href="#">Skilled nursing care</a>      | 25% <a href="#">coinsurance</a>                                                  | Not Covered                               | 90 days per benefit period<br>Prior authorization may be required.                                                                                                                                                                                                |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                    |                                           | Limitations, Exceptions, & Other Important Information                                        |
|----------------------------------------|-------------------------------------------|------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------|
|                                        |                                           | In Network<br>(You will pay the least)               | Out of Network<br>(You will pay the most) |                                                                                               |
|                                        | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a>                      | Not Covered                               | Prior authorization may be required.<br>Covered no limit.                                     |
|                                        | <a href="#">Hospice services</a>          | No Charge                                            | Not Covered                               | Prior authorization may be required.<br>Covered no limit.                                     |
| If your child needs dental or eye care | Children's eye exam                       | No Charge, <a href="#">Deductible</a> does not apply | Not Covered                               | 1 exam per year                                                                               |
|                                        | Children's glasses                        | No Charge, <a href="#">Deductible</a> does not apply | Not Covered                               | 1 item of children's eye glasses (with standard frames and lenses) or contact lenses per year |
|                                        | Children's dental check-up                | Not Covered                                          | Not Covered                               | None                                                                                          |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                     |                                                                                                                                                                                                                    |                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Abortion (except in cases of rape, incest, or when life of mother is endangered)</li> <li>Acupuncture</li> <li>Bariatric surgery</li> </ul>                                    | <ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Long-term care</li> </ul>                                                                                            | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Routine eye care (Adult)</li> <li>Weight loss programs</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                      |
| <ul style="list-style-type: none"> <li>Chiropractic care 12 visits per benefit period</li> <li>Hearing aids 1 item per ear per benefit period Limited to \$2,500 every 48 months for persons up to age 21.</li> </ul> | <ul style="list-style-type: none"> <li>Infertility treatment (limited to services such as diagnostic tests to find the cause of infertility)</li> <li>Private-duty nursing 90 visits per benefit period</li> </ul> | <ul style="list-style-type: none"> <li>Routine foot care</li> </ul>                                                                                                  |

**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](http://www.dol.gov/ebsa), 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), or Ohio Department of Insurance, 50 West Town Street #300, Columbus, OH 43215, Phone: 1-

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.amerihealthcaritasnext.com/content/dam/amerihealth-caritas/acnext/pdf/oh/2027/member/forms/evidence-of-coverage.pdf.coredownload.inline.pdf>

614-644-2658. Other options to continue coverage are 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: visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**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?** Not Applicable

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](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-350-2177.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-350-2177.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-350-2177.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-350-2177.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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> | \$2,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%     |
| ■ Other <a href="#">coinsurance</a>                             | 25%     |

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*)

|                    |          |
|--------------------|----------|
| Total Example Cost | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$2,500 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$1,900 |
| What isn't covered          |         |
| Limits or exclusions        | \$60    |
| The total Peg would pay is  | \$4,460 |

### 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> | \$2,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%     |
| ■ Other <a href="#">coinsurance</a>                             | 25%     |

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*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$900   |
| <a href="#">Copayments</a>  | \$700   |
| <a href="#">Coinsurance</a> | \$0     |
| What isn't covered          |         |
| Limits or exclusions        | \$20    |
| The total Joe would pay is  | \$1,620 |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%     |
| ■ Other <a href="#">coinsurance</a>                             | 25%     |

This EXAMPLE event includes services like:

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

|                    |         |
|--------------------|---------|
| Total Example Cost | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$2,200 |
| <a href="#">Copayments</a>  | \$200   |
| <a href="#">Coinsurance</a> | \$0     |
| What isn't covered          |         |
| Limits or exclusions        | \$0     |
| The total Mia would pay is  | \$2,400 |

## Notice of Nondiscrimination

AmeriHealth Caritas Next complies with applicable federal civil rights laws and does not discriminate on the basis of race; color; national origin; age; disability; or sex, including sex characteristics, including intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). AmeriHealth Caritas Next does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. AmeriHealth Caritas Next 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. If you need these services, contact the Member Services number on the back of your card. If you believe that AmeriHealth Caritas Next has failed to provide these services or discriminated in another way, you can file a grievance with AmeriHealth Caritas Next, Attention: Grievances, P.O. Box 7430 London, KY 40742-7430, fax: **1-844-329-2252**, or email [acaexchange grievance@amerihealthcaritas.com](mailto:acaexchange grievance@amerihealthcaritas.com).

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>.

## We speak your language

We provide free language services and information to people whose primary language is not English. To talk to an interpreter, call the Member Services number on the back of your card.

Ofrecemos servicios lingüísticos e información sin cargo a las personas cuya lengua materna no es el inglés. Para hablar con un intérprete, llame al número de Servicios al Miembro que figura en el dorso de su tarjeta.

我们为母语非英语的人士提供免费的语言服务及信息。如需与翻译交谈，请拨打您的会员卡背面的会员服务部电话。

Wir bieten Menschen, deren Muttersprache nicht Englisch ist, kostenlose Sprachdienste und Informationen an. Wenn Sie mit einem Dolmetscher oder einer Dolmetscherin sprechen möchten, rufen Sie bitte die Nummer des Mitgliederservice auf der Rückseite Ihrer Karte an.

نقدم خدمات ترجمة مجانية ومعلومات للأشخاص الذين لغتهم الأساسية ليست اللغة الإنجليزية. للتحدث مع مترجم، اتصل برقم خدمات الأعضاء الموجود على ظهر بطاقتك.

Mir hen Schprooch Hilfe un Information mitaus Koscht zu Leit des aerschde Schprooch net Englisch iss. Um mit en lwwersetzer zu schwetze, ruf die Member Services Nummer uff die Rickseit vun dei Kaard.

Мы предоставляем бесплатные языковые услуги и информацию людям, для которых английский не является родным. Чтобы обратиться к переводчику, позвоните по номеру, указанному на обратной стороне вашего удостоверения.

Nous fournissons gratuitement des services linguistiques et des informations à ceux dont la langue principale n'est pas l'anglais. Pour communiquer avec un interprète, appelez l'équipe service aux adhérents au numéro indiqué au dos de votre carte.

Chúng tôi cung cấp thông tin và các dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh. Để nói chuyện với thông dịch viên, hãy gọi đến số điện thoại của Dịch Vụ Hội Viên ở mặt sau thẻ của quý vị.

Namoota afaan isaanii inni jalqabaa Ingiliffa hin taaneef tajaajila afaanii fi odeeffannoo bilisaa ni kennina. Turjumaana waliin haasa'uuf, lakkoofsa Tajaajila Miseensootaa kan kaardii keessan dugda duuba jiru irratti bilbilaa.



영어가 주 언어가 아닌 사람들을 위해 무료로 언어 서비스와 정보를 제공합니다. 통역사와 대화하려면 가입자 카드 뒷면에 기재된 가입자 서비스 번호로 연락하십시오.

Offriamo servizi linguistici e informazioni gratuiti per individui la cui lingua principale non è l'inglese. Per parlare con un interprete, chiami il numero dei Servizi per i membri sul retro della sua tessera.

英語を母国語としない人々に、無料の言語サービスと情報を提供しています。通訳者と話すには、カード裏面に記載されているメンバーサービス番号に電話してください。

We bieden gratis taaldiensten en informatie aan mensen van wie de hoofdtal niet Engels is. Om met een tolk te spreken, belt u het nummer van Ledenservices op de achterkant van uw kaart.

Ми надаємо безкоштовні мовні послуги та інформацію людям, для яких англійська мова не є рідною. Для зв'язку з перекладачем зателефонуйте на номер відділу обслуговування, зазначений на зворотній стороні Вашої картки.