

 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 1-833-590-3300 (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 1-833-590-3300 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In Network: \$0/Individual, \$0/Family Out of Network: Not Covered	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. All covered health services are covered without a deductible.	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: \$9,400/Individual, \$18,800/Family 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.amerihhealthcaritasnext.com/de/">www.amerihhealthcaritasnext.com/de/</a> or call 1-833-590-3300 (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 (You will pay the least)	Out of Network (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.	\$55 <a href="#">copayment</a> /visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$110 <a href="#">copayment</a> /visit	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: 50% <a href="#">coinsurance</a> Blood work: 50% <a href="#">coinsurance</a>	X-ray: Not Covered Blood work: Not Covered	None
	Imaging (CT/PET scans, MRIs)	50% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered no limit.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://client.formularynavigator.com/Search.aspx?siteCode=6196104354">https://client.formularynavigator.com/Search.aspx?siteCode=6196104354</a>	Generic drugs	\$35 <a href="#">copayment</a> /prescription	Not Covered	Prior authorization / step therapy may be required. Covers up to a 90-day supply for retail and mail order prescriptions. 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.
	Preferred brand drugs	\$200 <a href="#">copayment</a> /prescription	Not Covered	
	Non-preferred brand drugs	50% <a href="#">coinsurance</a>	Not Covered	
	<a href="#">Specialty drugs</a>	50% <a href="#">coinsurance</a>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered no limit.
	Physician/surgeon fees	50% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered no limit.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://amerihealthcaritasnext.com/de/pdf/member/forms/evidence-of-coverage.pdf>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	50% <a href="#">coinsurance</a>	50% <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>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$80 <a href="#">copayment</a> /visit	Not Covered	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)	50% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered no limit.
	Physician/surgeon fees	50% <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	\$55 <a href="#">copayment</a> /visit	Not Covered	Prior authorization may be required. Covered no limit.
	Inpatient services	50% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered no limit.
If you are pregnant	Office visits	50% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. <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	50% <a href="#">coinsurance</a>	Not Covered	
	Childbirth/delivery facility services	50% <a href="#">coinsurance</a>	Not Covered	
	<a href="#">Home health care</a>	50% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. 100 visits per benefit period

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Rehabilitation services</a>	50% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. 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 back pain are not subject to these limits.
	<a href="#">Habilitation services</a>	50% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. 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 back pain are not subject to these limits.
	<a href="#">Skilled nursing care</a>	50% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. 120 days per admission
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered no limit.
	<a href="#">Hospice services</a>	50% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered no limit.
If your child needs dental or eye care	Children's eye exam	50% <a href="#">coinsurance</a>	Not Covered	1 exam per benefit period
	Children's glasses	50% <a href="#">coinsurance</a>	Not Covered	1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period
	Children's dental check-up	Not Covered	Not Covered	None

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## Excluded Services & Other Covered Services:

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

- Abortion (except in cases of rape, incest, or when life of mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care Up to 3 modalities per visit; maximum of one visit per day.
- Hearing aids 1 wearable item per impaired ear per 3 years
- Infertility treatment 6 procedures per lifetime
- Private-duty nursing 240 hours per benefit period
- Routine foot care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](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 Delaware Department of Insurance, 1351 W. North Street, Suite 101, Dover, DE 19904, Phone 1-302-674-7300. 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 1-833-590-3300.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-590-3300.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-590-3300.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-590-3300.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://amerihealthcaritasnext.com/de/pdf/member/forms/evidence-of-coverage.pdf>

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

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$110
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$6,300
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$6,370</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$110
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$3,300
<a href="#">Coinsurance</a>	\$500
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$3,800</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$110
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$1,200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>