

 **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 1-833-613-2262 (TTY 1-844-214-2471). 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 1-833-613-2262 (TTY 1-844-214-2471) to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>In Network:</b> \$5,800/Individual, \$11,600/Family <b>Out of Network:</b> 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care/screening</a> /immunization, Primary Care, <a href="#">Specialist</a> Care, <a href="#">Urgent Care</a> , and Mental/Behavioral Health and Substance Abuse Outpatient Services 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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>In Network:</b> \$8,900/Individual, \$17,800/Family <b>Out of Network:</b> 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain preauthorization 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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.amerhealth.com">www.amerhealth.com</a> or call 1-833-613-2262 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness.	\$40 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply	Not Covered	None
	<a href="#">Specialist</a> visit	\$80 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply	Not Covered	None
	<a href="#">Preventive care/screening</a> /immunization	No Charge	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: 40% <a href="#">coinsurance</a> Blood work: 40% <a href="#">coinsurance</a>	X-ray: Not Covered Blood work: Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered No limit.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://client.formularynavigator.com/Search.aspx?siteCode=8334465249">https://client.formularynavigator.com/Search.aspx?siteCode=8334465249</a>	Generic drugs	\$20 <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.
	Preferred brand drugs	\$40 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply	Not Covered	
	Non-preferred brand drugs	\$80 <a href="#">copayment</a> /prescription	Not Covered	
	<a href="#">Specialty drugs</a>	\$350 <a href="#">copayment</a> /prescription	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <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/fl/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)	
	Physician/surgeon fees	40% <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>	40% <a href="#">coinsurance</a>	40% <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>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$60 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply	Not Covered	Out-of-network <a href="#">Urgent Care</a> services are covered when network providers 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)	40% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered No limit.
	Physician/surgeon fees	40% <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	\$40 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply	Not Covered	Prior authorization may be required. Covered No limit.
	Inpatient services	40% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered No limit.
If you are pregnant	Office visits	40% <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	40% <a href="#">coinsurance</a>	Not Covered	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	Not Covered	
	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://amerihealthcaritasnext.com/fl/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)	
<b>If you need help recovering or have other special health needs</b>				20 days per benefit period
	<a href="#">Rehabilitation services</a>	40% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Combined limit of 35 visits per benefit period for all outpatient therapy and Chiropractic Care.
	<a href="#">Habilitation services</a>	40% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered No limit.
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. 60 days per benefit period
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered No limit.
	<a href="#">Hospice services</a>	40% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered No limit.
<b>If your child needs dental or eye care</b>	Children's eye exam	40% <a href="#">coinsurance</a>	Not Covered	1 exam per benefit period
	Children's glasses	40% <a href="#">coinsurance</a>	Not Covered	1 item per benefit period
	Children's dental check-up	Not Covered	Not Covered	None

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

## 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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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.)

- Chiropractic care Combined limit of 35 visits per benefit period for all outpatient therapy and Chiropractic Care
- 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 North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201, Phone No. 1-800-546-5664 or 1-919-807-6750. 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?

[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?

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 1-833-613-2262.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-613-2262.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-613-2262.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-613-2262.

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

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

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.

<b>Peg is Having a Baby</b> (9 months of in-network pre-natal care and a hospital delivery)	<b>Managing Joe's type 2 Diabetes</b> (a year of routine in-network care of a well-controlled condition)	<b>Mia's Simple Fracture</b> (in-network emergency room visit and follow up care)
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| <ul style="list-style-type: none"> <li>■ The <a href="#">plan's</a> overall <a href="#">deductible</a> <span style="float: right;">\$5,800</span></li> <li>■ <a href="#">Specialist copayment</a> <span style="float: right;">\$80</span></li> <li>■ Hospital (facility) <a href="#">coinsurance</a> <span style="float: right;">40%</span></li> <li>■ Other <a href="#">coinsurance</a> <span style="float: right;">40%</span></li> </ul> | <ul style="list-style-type: none"> <li>■ The <a href="#">plan's</a> overall <a href="#">deductible</a> <span style="float: right;">\$5,800</span></li> <li>■ <a href="#">Specialist copayment</a> <span style="float: right;">\$80</span></li> <li>■ Hospital (facility) <a href="#">coinsurance</a> <span style="float: right;">40%</span></li> <li>■ Other <a href="#">coinsurance</a> <span style="float: right;">40%</span></li> </ul> | <ul style="list-style-type: none"> <li>■ The <a href="#">plan's</a> overall <a href="#">deductible</a> <span style="float: right;">\$5,800</span></li> <li>■ <a href="#">Specialist copayment</a> <span style="float: right;">\$80</span></li> <li>■ Hospital (facility) <a href="#">coinsurance</a> <span style="float: right;">40%</span></li> <li>■ Other <a href="#">coinsurance</a> <span style="float: right;">40%</span></li> </ul> |
|--|--|--|

<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Specialist</a> office visits (<i>prenatal care</i>)                  Childbirth/Delivery Professional Services                  Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>	<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>	<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>
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<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
<a href="#">Deductibles</a>	\$5,800	<a href="#">Deductibles</a>	\$900	<a href="#">Deductibles</a>	\$2,100
<a href="#">Copayments</a>	\$70	<a href="#">Copayments</a>	\$1,200	<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$2,700	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$8,570</b>	<b>The total Joe would pay is</b>	<b>\$2,100</b>	<b>The total Mia would pay is</b>	<b>\$2,500</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.