

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

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | \$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or In Network: \$9,450/Individual, \$18,900/Family Out of Network: Not Covered | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible? | Yes. Preventive care/screening /immunization do not apply toward the deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | In Network: \$9,450/Individual, \$18,900/Family Out of Network: Not Covered | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums , balance-billing charges, penalties for failure to obtain preauthorization for services and health care this plan does not cover. | Even though you pay these expenses they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider? | Yes. See www.amerithealthcaritasnext.com/nc/ or call 1-833-613-2262 (TTY 1-844-214-2471) for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral . |



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 |
|--|---|--|--|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP Provider In-Network Provider (You will pay less) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness. | No Charge | No Charge | Not Covered | None |
| | Specialist visit | No Charge | No Charge | Not Covered | None |
| | Preventive care/screening /immunization | No Charge | No Charge, Deductible does not apply | Not Covered | You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | No Charge | X-ray: No Charge Blood work: No Charge | X-ray: Not Covered Blood work: Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | No Charge | No Charge | Not Covered | Prior authorization may be required. Covered no limit. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at [https://client.formularynavigator.com/Search.aspx?siteCode=8328875357] | Generic drugs | No Charge | No Charge | Not Covered | Prior authorization / step therapy may be required. Covers up to a 30-day supply for retail prescriptions; 31–90 day supply for mail order prescriptions. Cost share shown is per retail prescription per 30-day supply. Mail order cost share is the same as retail prescription at 2 copayments |
| | Preferred brand drugs | No Charge | No Charge | Not Covered | |
| | Non-preferred brand drugs | No Charge | No Charge | Not Covered | |
| | Specialty drugs | No Charge | No Charge | Not Covered | |

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

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|--|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP Provider In-Network Provider (You will pay less) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| | | | | | for a 31-60 day supply and 3 copayments for a 61-90 day supply. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | No Charge | Not Covered | Prior authorization may be required. Covered no limit. |
| | Physician/surgeon fees | No Charge | No Charge | Not Covered | Prior authorization may be required. Covered no limit. |
| If you need immediate medical attention | Emergency room care | No Charge | No Charge | No Charge | You pay the same level as in-network if it is an emergency as defined in your policy, otherwise not covered. |
| | Emergency medical transportation | No Charge | No Charge | No Charge | None |
| | Urgent care | No Charge | No Charge | Not Covered | Out-of-network Urgent Care services are covered when network providers are temporarily unavailable or inaccessible and if the services are for an urgent condition as defined in your plan policy, otherwise not covered. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | No Charge | Not Covered | Prior authorization may be required. Covered no limit. |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|--|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP Provider In-Network Provider (You will pay less) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| | Physician/surgeon fees | No Charge | No Charge | Not Covered | Prior authorization may be required. Covered no limit. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No Charge | No Charge | Not Covered | Prior authorization may be required. Covered no limit. |
| | Inpatient services | No Charge | No Charge | Not Covered | Prior authorization may be required. Covered no limit. |
| If you are pregnant | Office visits | No Charge | No Charge | Not Covered | Prior authorization may be required. Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | No Charge | No Charge | Not Covered | |
| | Childbirth/delivery facility services | No Charge | No Charge | Not Covered | |
| If you need help recovering or have other special health needs | Home health care | No Charge | No Charge | Not Covered | Prior authorization may be required. |
| | Rehabilitation services | No Charge | No Charge | Not Covered | Prior authorization may be required. Combined limit of 30 visits per benefit period for Rehabilitative Chiropractic Care, Physical Therapy, and Occupational Therapy. |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|--|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP Provider In-Network Provider (You will pay less) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| | Habilitation services | No Charge | No Charge | Not Covered | Prior authorization may be required. Combined limit of 30 visits per benefit period for Habilitative Chiropractic Care, Physical Therapy, and Occupational Therapy. |
| | Skilled nursing care | No Charge | No Charge | Not Covered | Prior authorization may be required. 60 days per benefit period |
| | Durable medical equipment | No Charge | No Charge | Not Covered | Prior authorization may be required. Covered no limit. |
| | Hospice services | No Charge | No Charge | Not Covered | Prior authorization may be required. Covered no limit. |
| If your child needs dental or eye care | Children's eye exam | No Charge | No Charge | Not Covered | 1 exam per benefit period |
| | Children's glasses | No Charge | No Charge | 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 | 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 Combined limit of 30 visits per benefit period for Habilitative Chiropractic Care, Physical Therapy, and Occupational Therapy; Combined limit of 30 visits per benefit period for Rehabilitative Chiropractic Care, Physical Therapy, and Occupational Therapy.
- Hearing aids 1 item per impaired ear per 3 years
- Infertility treatment 3 treatments per lifetime
- Private-duty nursing
- 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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 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 1-833-613-2262.

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

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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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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) | | Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|-----------------|---|----------------|---|----------------|
| ■ The plan's overall deductible | \$0 | ■ The plan's overall deductible | \$0 | ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$0 | ■ Specialist copayment | \$0 | ■ Specialist copayment | \$0 |
| ■ Hospital (facility) copayment | \$0 | ■ Hospital (facility) copayment | \$0 | ■ Hospital (facility) copayment | \$0 |
| ■ Other copayment | \$0 | ■ Other copayment | \$0 | ■ Other copayment | \$0 |
| <p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>) | | <p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>) | | <p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>) | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| <i>Cost Sharing</i> | | <i>Cost Sharing</i> | | <i>Cost Sharing</i> | |
| Deductibles | \$0 | Deductibles | \$0 | Deductibles | \$0 |
| Copayments | \$0 | Copayments | \$0 | Copayments | \$0 |
| Coinsurance | \$0 | Coinsurance | \$0 | Coinsurance | \$0 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$0 | Limits or exclusions | \$0 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$0 | The total Joe would pay is | \$0 | The total Mia would pay is | \$0 |

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.