

 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 1-844-352-1706 or visit us at www.amerihealth.com/tpa. For 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-844-352-1706 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$350.00 Individual / \$700.00 Family per calendar year for Out-of-Network providers .	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 is covered before you meet your 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 ?	For Active employee In-Network health providers \$500.00 Individual / \$1,000.00 Family. Retiree In-Network health providers \$500.00 Individual / \$1,000.00 Family. Out-of-Network providers \$2,000.00 Individual / \$5,000.00 Family.	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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-bill charges, health care this plan doesn't cover, and preauthorization penalties.	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.amerihealth.com/tpa or call: 1-844-352-1706 for a list of In- 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
		In-Network Provider (You will pay the least)	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	\$10 copay per visit	30% coinsurance	Out-of-Network allowances for Chiropractic, Acupuncture, and Physical Therapy services are limited to no more than \$35.00 per visit for Chiropractic, \$60.00 per visit for Acupuncture, and \$52.00 per visit for Physical Therapy or 75% of the In-Network cost per visit, whichever is less. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. One per calendar year.
	Specialist visit	\$15 copay per visit	30% coinsurance	
	Preventive care/screening/immunization	No Charge	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance	Preauthorization is required for some imaging services. There is a 20% reduction in benefits for failure to obtain preauthorization .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	\$5 copay per fill retail \$10 copay per fill mail order	Not Covered	• Up to 30-day supply at retail; 90-day mail order. • Step Therapy with NO Grandfathering applies. • For Brand drugs with a Generic Equivalent available, member pays the difference in cost between generic & brand, plus brand copay.
	Preferred brand drugs	\$10 copay per fill retail \$20 copay per fill mail order	Not Covered	
	Non-preferred drugs	\$10 copay per fill retail \$20 copay per fill mail order	Not Covered	
	Specialty drugs	Follows retail	Not Covered	Accredo specialty pharmacy mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance	Preauthorization is required for some outpatient surgeries. There is a 20% reduction in benefits for failure to obtain preauthorization .
	Physician/surgeon fees	No Charge	30% coinsurance	30% coinsurance for Out-of-Network anesthesia. Preauthorization is required for some outpatient surgeries. There is a 20% reduction in benefits for failure to obtain preauthorization .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$125 copay per visit for outpatient hospital	\$125 copay per visit for outpatient hospital. Deductible does not apply.	If admitted within 24 hours, the copay is waived. Payment at the In-Network level applies only to true medical emergencies & accidental injuries.
	Emergency medical transportation	10% coinsurance	30% coinsurance	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.
	Urgent care	\$15 copay per visit for Specialist	30% coinsurance for Specialist	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge for inpatient hospital	30% coinsurance for inpatient hospital	Preauthorization is required. There is a 20% reduction in benefits for failure to obtain preauthorization .
	Physician/surgeon fees	No Charge for inpatient hospital	30% coinsurance for inpatient hospital	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge for outpatient hospital. \$15 copay per office visit for mental health and behavioral health. No Charge for substance abuse office visit.	30% coinsurance for outpatient hospital	Some specialty outpatient services require preauthorization . There is a 20% reduction in benefits for failure to obtain preauthorization when required.
	Inpatient services	No Charge for inpatient hospital	30% coinsurance for inpatient hospital	Preauthorization is required. There is a 20% reduction in benefits for failure to obtain preauthorization .
If you are pregnant	Office visits	\$10 copay per visit for office. \$15 copay per visit for specialist .	30% coinsurance	Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	30% coinsurance	Preauthorization is required. There is a 20% reduction in benefits for failure to obtain preauthorization .
	Childbirth/delivery facility services	No Charge	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	Preauthorization is required. There is a 20% reduction in benefits for failure to obtain preauthorization .
	Rehabilitation services	No Charge for inpatient and outpatient facility. \$15 copay per visit for office.	30% coinsurance	Preauthorization may be required for some therapies. There is a 20% reduction in benefits for failure to obtain preauthorization when required. Out-of-Network allowance for Physical Therapy services is limited to \$52 per visit or 75% of the In-Network cost per visit, whichever is less.
	Habilitation services	No Charge for inpatient and outpatient facility. \$15 copay per visit for office.	30% coinsurance	
	Skilled nursing care	No Charge	30% coinsurance	Preauthorization is required. There is a 20% reduction in benefits for failure to obtain preauthorization . Limited to 120 days In-Network and 60 Out-of-Network facility days for a combined maximum of 120 days per calendar year.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is required for all rentals and some purchases. There is a 20% reduction in benefits for failure to obtain preauthorization when required.
	Hospice services	No Charge	30% coinsurance	Preauthorization is required. There is a 20% reduction in benefits for failure to obtain preauthorization .
If your child needs dental or eye care	Children's eye exam	\$15 copay per visit	Not Covered	Limited to one exam per calendar year.
	Children's glasses	Not Covered	Not Covered	---None---
	Children's dental check-up	Not Covered	Not Covered	---None---

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](#).)

- | | | |
|--|---|--|
| <ul style="list-style-type: none">• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Long Term Care• Private-duty nursing | <ul style="list-style-type: none">• Routine foot care• Weight loss programs |
|--|---|--|

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

- | | | |
|--|---|---|
| <ul style="list-style-type: none">• Acupuncture (For pain management only)• Bariatric surgery (Requires preauthorization)• Chiropractic care (30 visits/calendar year) | <ul style="list-style-type: none">• Hearing Aids (Only covered for members age 15 or younger)• Infertility Treatment (Requires preauthorization)• Most coverage provided outside the U.S. (Subject to deductible/coinsurance and balance billing) | <ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Routine eye care (Adult) |
|--|---|---|

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-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be 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 on how 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: 1-844-352-1706 or www.amerihhealth.com/tpa. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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? **Yes**

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](#).

Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services

AmeriHealth Administrators complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AmeriHealth Administrators does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AmeriHealth Administrators:

- Provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- Provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that AmeriHealth Administrators has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

There are four ways to file a grievance directly with AmeriHealth Administrators:

- by mail: AmeriHealth Administrators,
ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 844-352-1706 (TTY 711);
- by fax: 215-761-0920; or
- by email: AHACivilRightsCoordinator@ahatpa.com.

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

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 or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Access Services:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-352-1706 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-352-1706 (TTY: 711).

注意: 如果您使用简体中文, 您可以免费获得语言协助服务。请致电1-844-352-1706。

LƯU Ý: Nếu quý vị nói tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-844-352-1706.

ВНИМАНИЕ: Если вы говорите по-русски, вам предлагаются бесплатные услуги переводчика. Позвоните по телефону 1-844-352-1706.

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannst du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-352-1706.

알림: 한국어 통역서비스가 필요한 분은 1-844-352-1706로 전화하십시오.

통역서비스를 무료로 받으실 수 있습니다.

ATTENZIONE: se parla italiano, sono disponibili per lei servizi di assistenza linguistica gratuiti. Contatti il numero 1-844-352-1706.

انتباه: إذا كنت تتحدث العربية فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على الرقم: 1-844-352-1706.

ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le 1-844-352-1706.

HINWEIS: Wenn Sie Deutsch sprechen, steht Ihnen über Language Assistance Services ein Dolmetscher kostenlos zur Verfügung. Wählen Sie 1-844-352-1706.

ધ્યાન આપો : જો તમે ગુજરાતી બોલી શકતા હો, તો તમારા માટે ભાષા સહાય સેવાઓ, વિના મૂલ્યે, ઉપલબ્ધ છે. 1-844-352-1706 પર કોલ કરો.

UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-352-1706.

ATANSYON: Si ou pale kreyòl ayisyen, gen asistans ak lang disponib pou ou gratis. Rele 1-844-352-1706.

ចំណាំ: ប្រសិនបើអ្នកនិយាយភាសា មន-ខ្មែរ ប្រទេសខ្មែរ សេវាជំនួយភាសាដែលឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ 1-844-352-1706។

ATENÇÃO: se você fala português, serviços de assistência a idioma estão disponíveis gratuitamente para você. Ligue para 1-844-352-1706.

BAA !KON&N&ZIN: Din4 bizaad bee yln7[ti'go, ata' hane' bee lk1 i'iilyeed t'l1 j77k'e bee n1 ah00t'i'. Koj8' hod77lnih 1-844-352-1706.

PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong para sa wika nang walang bayad. Tumawag sa 1-844-352-1706.

注意: 日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。1-844-352-1706にお電話ください。

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان، به رایگان در اختیار شما می باشد. با شماره 1-844-352-1706 تماس بگیرید.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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	\$15
■ Hospital (facility) no cost sharing	\$0
■ Other no cost sharing	\$0

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	
Deductibles	\$0
Copayments	\$20
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$80

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	\$15
■ Hospital (facility) no cost sharing	\$0
■ Other no cost sharing	\$0

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	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$80
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$500

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) no cost sharing	\$0
■ Other no cost sharing	\$0

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	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$400

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