


**⚠ 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.amerhealth.com/tpa](http://www.amerhealth.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:
<b>What is the overall <a href="#">deductible</a>?</b>	In-Network <b>\$3,500</b> person / <b>\$7,000</b> family, Out-of-Network <b>\$7,000</b> person / <b>\$14,000</b> family.	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="#">In-Network preventive care</a> , emergency care, and services that require a <a href="#">copay</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>	For <a href="#">In-Network providers</a> <b>\$6,000</b> person / <b>\$12,000</b> family, for <a href="#">Out-of-Network providers</a> <b>\$12,000</b> person / <b>\$24,000</b> family.	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 limits</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> , balance-bill charges, health care this <a href="#">plan</a> doesn't cover, and <a href="#">preauthorization</a> penalties.	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/tpa">www.amerhealth.com/tpa</a> or call: <b>1-844-352-1706</b> for a list of <a href="#">In-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 plan's <a href="#">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 provider's 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 Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$35 <a href="#">copay</a> per visit <a href="#">Deductible</a> waived	50% <a href="#">coinsurance</a>	---None---
	<a href="#">Specialist</a> visit	\$70 <a href="#">copay</a> per visit <a href="#">Deductible</a> waived	50% <a href="#">coinsurance</a>	---None---
	<a href="#">Preventive care/screening/immunization</a>	No Charge <a href="#">Deductible</a> waived	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. 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)	\$70 <a href="#">copay</a> per visit <a href="#">Deductible</a> waived	50% <a href="#">coinsurance</a>	---None---
	Imaging (CT/PET scans, MRIs)	\$70 <a href="#">copay</a> per scan <a href="#">Deductible</a> waived	50% <a href="#">coinsurance</a>	Precertification is required for some imaging services. Coverage may be denied if precertification is not obtained.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	\$15 <a href="#">copay</a> per fill retail \$30 <a href="#">copay</a> per fill mail order	Not Covered	30-day supply retail, 90-day supply mail order.  <a href="#">Prescription Drugs</a> are covered through Express Scripts and are excluded from the AmeriHealth Administrators <a href="#">plan</a> .
	Preferred brand drugs	\$35 <a href="#">copay</a> per fill retail \$70 <a href="#">copay</a> per fill mail order	Not Covered	
	Non-preferred drugs	\$50 <a href="#">copay</a> per fill retail \$100 <a href="#">copay</a> per fill mail order	Not Covered	
	<a href="#">Specialty drugs</a>	Same as retail	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <a href="#">copay</a> per visit <a href="#">Deductible</a> waived	50% <a href="#">coinsurance</a>	Precertification may be required for some outpatient surgeries. Coverage may be denied if precertification is not obtained.
	Physician/surgeon fees	No Charge after <a href="#">deductible</a>	50% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> per visit <a href="#">Deductible</a> waived	\$150 <a href="#">copay</a> per visit <a href="#">Deductible</a> waived	No coverage for non-emergency use.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> after <a href="#">In-Network deductible</a>	Non-emergency transport: not covered, except 50% <a href="#">coinsurance</a> if pre-authorized.
	<a href="#">Urgent care</a>	\$70 <a href="#">copay</a> per visit <a href="#">Deductible</a> waived	\$70 <a href="#">copay</a> per visit <a href="#">Deductible</a> waived	---None---

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 have a hospital stay	Facility fee (e.g., hospital room)	\$200 <a href="#">copay</a> per day up to 5 <a href="#">copays</a> per admission. <a href="#">Deductible</a> waived	50% <a href="#">coinsurance</a>	Precertification is required. Coverage may be denied if precertification is not obtained.
	Physician/surgeon fees	No Charge after <a href="#">deductible</a>	50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$70 <a href="#">copay</a> per visit. <a href="#">Deductible</a> waived	Office & other outpatient services: 50% <a href="#">coinsurance</a>	---None---
	Inpatient services	\$200 <a href="#">copay</a> per day up to 5 <a href="#">copays</a> per admission. <a href="#">Deductible</a> waived	50% <a href="#">coinsurance</a>	Precertification is required. Coverage may be denied if precertification is not obtained.
If you are pregnant	Office visits	No Charge after <a href="#">deductible</a>	50% <a href="#">coinsurance</a>	<a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Precertification may be required for inpatient delivery services. Coverage may be denied if precertification is not obtained.
	Childbirth/delivery professional services	No Charge after <a href="#">deductible</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$200 <a href="#">copay</a> per day up to 5 <a href="#">copays</a> per admission. <a href="#">Deductible</a> waived	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 120 visits per calendar year, including up to 70 8-hour shifts for private duty nursing. Precertification is required. Coverage may be denied if precertification is not obtained.
	<a href="#">Rehabilitation services</a>	\$70 <a href="#">copay</a> per visit <a href="#">Deductible</a> waived	50% <a href="#">coinsurance</a>	Limited to 60 visits per condition/calendar year for Physical, Occupational, & Speech therapies combined, including outpatient hospital services.
	<a href="#">Habilitation services</a>	\$70 <a href="#">copay</a> per visit <a href="#">Deductible</a> waived	50% <a href="#">coinsurance</a>	Limited to treatment of Autism.
	<a href="#">Skilled nursing care</a>	\$200 <a href="#">copay</a> per day up to 5 <a href="#">copays</a> per admission. <a href="#">Deductible</a> waived	50% <a href="#">coinsurance</a>	Limited to 120 days per calendar year. Precertification is required. Coverage may be denied if precertification is not obtained.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to one <a href="#">durable medical equipment</a> item for same/similar purpose. Excludes repairs for misuse/abuse.

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)	
	<a href="#">Hospice services</a>	Inpatient: \$200 <a href="#">copay</a> per day up to 5 <a href="#">copays</a> per admission. <a href="#">Deductible</a> waived. Outpatient: 30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Precertification is required. Coverage may be denied if precertification is not obtained.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one routine eye exam per 24 months.
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss programs (except for required <a href="#">preventive services</a>)</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>• Acupuncture</li> <li>• Bariatric surgery (<a href="#">In-Network providers</a> only)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (30 visits per calendar year)</li> <li>• Infertility Treatment (limitations apply)</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing (included as part of <a href="#">home health care</a>)</li> <li>• Routine eye care (Adult) (1 exam per 24 months, <a href="#">In-Network</a> only)</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-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](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 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](http://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](http://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](mailto: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)] schwetzsch, kannsch 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 ហៅជំនួយភាសាដែលឥតគិតថ្លៃមានសម្រាប់អ្នក។ 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 1k1 i'iilyeed t'l1 j77k'e bee n1 ah00't'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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,500
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">copayment</a>	\$200
■ Other no <a href="#">cost sharing</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,060</b>

### 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>	\$3,500
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">copayment</a>	\$200
■ Other no <a href="#">cost sharing</a>	\$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$300
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,920</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,500
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">copayment</a>	\$200
■ Other no <a href="#">cost sharing</a>	\$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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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