Schedule of Benefits

AmeriHealth Caritas Next Bronze Signature + No Referrals

Benefit period: From 01/01/2025 through 12/31/2025 Calendar Year.

About your Schedule of Benefits

This Schedule of Benefits outlines services that may be covered under your health benefit plan. Please refer to the Evidence of Coverage (EOC) document for more details on covered health services and important limitations. Your EOC also describes preventive services covered with no cost-sharing. As a member, you are responsible for the deductible, copayments, and coinsurance for eligible services.

Coinsurance

A percentage of the allowed amount you are required to pay for covered health services and prescription drugs, for example 20%. A copayment is not a coinsurance.

Copayment

A specific dollar amount you may be required to pay as your share of the allowed amount for covered health services or prescription drugs you receive. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug. A copayment is not a coinsurance.

Deductible

The amount you must pay for covered health services or prescription drugs each year before the health benefit plan begins to pay.

Limitations and Exclusions

Some benefit limitations and exclusions are outlined on p. 3-7 below. Please review your EOC and other policy documents. These give a full description of services and items that are limited or not covered by your health benefit plan.

Out-of-Pocket Maximum

The most that you pay out-of-pocket during the calendar year for in-network covered health services. It includes deductibles and any cost-sharing amounts the member has paid. Amounts you pay for premiums do not count toward the out-of-pocket maximum amount.

Quantity Limits

A tool to limit the use of selected drugs for quality, safety, or utilization reasons. Drugs may be limited by the amount that we cover per prescription or for a defined period of time.

Prior Authorization

Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from your health benefit plan.

Note:

AmeriHealth Caritas Next plans do not offer embedded pediatric dental coverage as there are stand-alone pediatric dental plans available in the exchange for purchase. AmeriHealth Caritas Next will inform consumers of the availability of stand-alone pediatric dental plans during the plan selection and enrollment process.

Your Deductible and Out-of-Pocket Maximum

This Benefit Overview describes your coverage and Cost Sharing Amounts, including Deductible and Out-of-Pocket Maximum, under this plan.

General Cost Share & Features	In Network	Out of Network
Deductible: - Per Calendar Year - Medical and Drug Combined - Some services do not apply to the deductible, as indicated below.	$7,500/Individual $15,000/Family	Not Covered
Out-of-Pocket Maximum: - Per Calendar Year - Medical and Drug Combined	$9,200/Individual $18,400/Family	Not Covered

If you are the subscriber, and the only member covered under your health benefit plan, the individual out-of-pocket maximum amount applies. If you have other family members on your plan, the family out-of-pocket maximum amount applies. The plan has an embedded individual out-of-pocket maximum within the family out-of-pocket maximum. No one member can contribute more than their individual out-of-pocket maximum amount to the family out-of-pocket maximum. Copayment or coinsurance amounts a member pays for services shown as covered without an out-of-pocket maximum will not count toward meeting the individual or family out-of-pocket maximum.

Benefit Details

The following table provides basic information about your benefits under this plan.

Benefit	In Network	Out of Network
Primary & Specialist Office Visits		
Other Practitioner Office Visit (Nurse, Physician Assistant)	$50 Copay per visit	Not Covered
Primary Care Visit to Treat an Injury or Illness	$50 Copay per visit	Not Covered
Routine Foot Care	$100 Copay per visit	Not Covered
Specialist Visit	$100 Copay per visit	Not Covered
Virtual Care 24/7 *Virtual care visits offered through AmeriHealth Caritas Next Virtual Care 24/7 are covered at No Charge; your deductible does not apply. Otherwise, virtual care visits are subject to the same cost sharing responsibilities as office visits.*	No Charge	Not Covered
Preventive Care		
Newborn Hearing Screening	No Charge	Not Covered
Nutritional Counseling	No Charge	Not Covered
Preventive Care/Screening/Immunization	No Charge	Not Covered
Well Baby Visits and Care	No Charge	Not Covered

Benefit	In Network	Out of Network
Therapy		
Chiropractic Care *Up to 3 modalities per visit; maximum of one visit per day.*	Deductible, then 50% Coinsurance	Not Covered
Habilitation Services† *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.*	$50 Copay per visit	Not Covered
Outpatient Rehabilitation Services† *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.*	$50 Copay per visit	Not Covered
Rehabilitative Occupational and Rehabilitative Physical Therapy† *Combined limit of 30 visits per benefit period for Rehabilitative Physical Therapy and Occupational Therapy. Physical therapy visits for the treatment of back pain are not subject to these limits.*	$50 Copay per visit	Not Covered
Rehabilitative Speech Therapy† *30 visits per benefit period*	$50 Copay per visit	Not Covered
Infusion Therapy†	Deductible, then 50% Coinsurance	Not Covered
Chemotherapy†	Deductible, then 50% Coinsurance	Not Covered
Radiation	Deductible, then 50% Coinsurance	Not Covered
Diagnostic & Imaging		
Imaging (CT/PET Scans, MRIs)†	Deductible, then 50% Coinsurance	Not Covered
Laboratory Outpatient and Professional Services†	Deductible, then 50% Coinsurance	Not Covered
X-rays and Diagnostic Imaging	Deductible, then 50% Coinsurance	Not Covered
Outpatient Care		
Mental/Behavioral Health Outpatient Services†	$50 Copay per visit	Not Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)†	Deductible, then 50% Coinsurance	Not Covered
Outpatient Surgery Physician/Surgical Services†	Deductible, then 50% Coinsurance	Not Covered
Substance Abuse Disorder Outpatient Services†	$50 Copay per visit	Not Covered

Benefit	In Network	Out of Network
Inpatient Care		
Delivery and All Inpatient Services for Maternity Care†	Deductible, then 50% Coinsurance	Not Covered
Inpatient Hospital Services (e.g., Hospital Stay)†	Deductible, then 50% Coinsurance	Not Covered
Inpatient Physician and Surgical Services†	Deductible, then 50% Coinsurance	Not Covered
Mental/Behavioral Health Inpatient Services†	Deductible, then 50% Coinsurance	Not Covered
Skilled Nursing Facility† *120 days per admission*	Deductible, then 50% Coinsurance	Not Covered
Substance Abuse Disorder Inpatient Services†	Deductible, then 50% Coinsurance	Not Covered
Hospice Care		
Hospice Services†	Deductible, then No Charge	Not Covered
Home Health Care, Nursing Home Care, and Private Duty Nursing		
Home Health Care Services† *100 visits per benefit period*	Deductible, then 50% Coinsurance	Not Covered
Long-Term/Custodial Nursing Home Care	Not Covered	Not Covered
Private-Duty Nursing† *240 hours per benefit period*	Deductible, then 50% Coinsurance	Not Covered
Urgent Care		
Urgent Care Centers or Facilities	$75 Copay per visit	
Emergency Care/Ambulance		
Emergency Room Services	Deductible, then 50% Coinsurance	
Emergency Transportation/Ambulance	Deductible, then 50% Coinsurance	
Durable Medical Equipment and Devices		
Durable Medical Equipment†	Deductible, then 50% Coinsurance	Not Covered
Prosthetic Devices†	Deductible, then 50% Coinsurance	Not Covered
Dental Care		
Accidental Dental†	Deductible, then 50% Coinsurance	Not Covered
Basic Dental Care – Child	Not Covered	Not Covered
Basic Dental Care – Adult	Not Covered	Not Covered
Dental Check-Up for Children	Not Covered	Not Covered
Dental Services for Children with Severe Disabilities†	Deductible, then 50% Coinsurance	Not Covered
Major Dental Care – Child	Not Covered	Not Covered
Major Dental Care – Adult	Not Covered	Not Covered
Orthodontia – Child	Not Covered	Not Covered

Benefit	In Network	Out of Network
Orthodontia – Adult	Not Covered	Not Covered
Routine Dental Services (Adult)	Not Covered	Not Covered
Pediatric Vision Services **Covered through the last day of the month in which a child turns 19**		
Contact Lenses for Children *1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period*	Deductible, then 50% Coinsurance	Not Covered
Eye Glasses for Children *1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period*	Deductible, then 50% Coinsurance	Not Covered
Low Vision Exams and Aids for Children† *1 exam per 5 years*	Deductible, then 50% Coinsurance	Not Covered
Routine Eye Exam for Children *1 exam per benefit period*	Deductible, then 50% Coinsurance	Not Covered
Additional Services		
Abortion for Which Public Funding is Prohibited	Not Covered	Not Covered
Acupuncture	Not Covered	Not Covered
Allergy Testing	$100 Copay per visit	Not Covered
Autism Spectrum Disorders (ASD)†	Deductible, then 50% Coinsurance	Not Covered
Bariatric Surgery†	Deductible, then 50% Coinsurance	Not Covered
Cancer Monitoring Test	Deductible, then 50% Coinsurance	Not Covered
Cardiac Rehabilitation† *30 visits per benefit period*	Deductible, then 50% Coinsurance	Not Covered
Clinical Trials†	Deductible, then 50% Coinsurance	Not Covered
Cosmetic Surgery	Not Covered	Not Covered
Diabetes Care Management	Deductible, then 50% Coinsurance	Not Covered
Diabetes Education	No Charge	Not Covered
Dialysis	Deductible, then 50% Coinsurance	Not Covered
Hearing Aids† *1 wearable item per impaired ear per 3 years*	Deductible, then 50% Coinsurance	Not Covered
Infertility Treatment† *6 procedures per lifetime*	Deductible, then 50% Coinsurance	Not Covered
Inherited Metabolic Disorder - PKU†	Deductible, then 50% Coinsurance	Not Covered
Prenatal and Postnatal Care	No Charge	Not Covered
Pulmonary Rehabilitation† *36 treatments per benefit period*	Deductible, then 50% Coinsurance	Not Covered

Benefit	In Network	Out of Network
Reconstructive Surgery†	Deductible, then 50% Coinsurance	Not Covered
Routine Eye Exam (Adult)	Not Covered	Not Covered
Reversible Contraceptives	Deductible, then 50% Coinsurance	Not Covered
School Based Health Centers	Deductible, then 50% Coinsurance	Not Covered
Transplant†	Deductible, then 50% Coinsurance	Not Covered
Treatment for Temporomandibular Joint Disorders†	Deductible, then 50% Coinsurance	Not Covered
Weight Loss Programs	Not Covered	Not Covered

† Prior authorization may be required

Prescription Drugs

Prescription Deductible and Out-of-Pocket Maximum (OOPM)

Prescription Cost Share & Features	In Network	Out of Network
Deductible (Integrated with Medical Deductible)	$7,500/Individual $15,000/Family	Not Covered
Out of Pocket Maximum (Integrated with Medical Out of Pocket Maximum)	$9,200/Individual $18,400/Family	Not Covered

Retail Pharmacy (per 30 day supply)		
Tier	**In Network**	**Out of Network**
Generic Drugs	$25 Copay per prescription	Not Covered
Preferred Brand Drugs	Deductible, then $50 Copay per prescription	Not Covered
Non-Preferred Brand Drugs	Deductible, then $100 Copay per prescription	Not Covered
Specialty Drugs	Deductible, then $150 Copay per prescription	Not Covered

Prescription Drug Notes:

1. Covers up to a 90-day supply for retail and mail order prescriptions.
2. 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.
3. Prior authorization / step therapy may be required.