



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 1-833-590-3300 (TTY 711). 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 1-833-590-3300 (TTY 711) to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                                                                                                                                                                      | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | In Network: \$7,250/Individual, \$14,500/Family<br>Out of Network: 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, children's eye exam and glasses, Primary Care, <a href="#">Specialist Care</a> , <a href="#">Urgent Care</a> , <a href="#">Mental/Behavioral Health Office Visits</a> , and <a href="#">Substance Abuse Office Visits</a> 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> | In Network: \$10,600/Individual, \$21,200/Family<br>Out of Network: 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 <a href="#">preauthorization</a> 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.amerihhealthcaritasnext.com/de/">www.amerihhealthcaritasnext.com/de/</a> or call 1-833-590-3300 (TTY 711) 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<br>(You will pay the least)                                                  | Out of Network<br>(You will pay the most)     |                                                                                                                                                                                                                                                                                                                                                                                                         |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                                                                                                              | Primary care visit to treat an injury or illness.       | \$45 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply        | Not Covered                                   | None                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                     | <a href="#">Specialist</a> visit                        | \$110 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply       | Not Covered                                   | None                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                     | <a href="#">Preventive care/screening</a> /immunization | No Charge, <a href="#">Deductible</a> does not apply                                    | 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.                                                                                                                                                                             |
| If you have a test                                                                                                                                                                                                                                                                                  | <a href="#">Diagnostic test</a> (x-ray, blood work)     | X-ray: 35% <a href="#">coinsurance</a><br>Blood work: 35% <a href="#">coinsurance</a>   | X-ray: Not Covered<br>Blood work: Not Covered | None                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                     | Imaging (CT/PET scans, MRIs)                            | 35% <a href="#">coinsurance</a>                                                         | Not Covered                                   | Prior authorization may be required. Covered no limit.                                                                                                                                                                                                                                                                                                                                                  |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://client.formularynavigator.com/Search.aspx?siteCode=2222768445">https://client.formularynavigator.com/Search.aspx?siteCode=2222768445</a> | Generic drugs                                           | \$25 <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 90-day supply for retail and mail order prescriptions. 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. |
|                                                                                                                                                                                                                                                                                                     | Preferred brand drugs                                   | \$60 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply | Not Covered                                   |                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                     | Non-preferred brand drugs                               | \$125 <a href="#">copayment</a> /prescription                                           | Not Covered                                   |                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                     | <a href="#">Specialty drugs</a>                         | \$150 <a href="#">copayment</a> /prescription                                           | Not Covered                                   |                                                                                                                                                                                                                                                                                                                                                                                                         |
| If you have outpatient surgery                                                                                                                                                                                                                                                                      | Facility fee (e.g., ambulatory surgery center)          | 35% <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://www.amerithealthcaritasnext.com/content/dam/amerithealth-caritas/acnext/pdf/de/2026/member/forms/evidence-of-coverage.pdf.coredownload.inline.pdf>

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                                              |                                                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | In Network<br>(You will pay the least)                                                                                                                         | Out of Network<br>(You will pay the most)                                        |                                                                                                                                                                                                                                                                                                       |
|                                                                           | Physician/surgeon fees                           | 35% <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>              | 35% <a href="#">coinsurance</a>                                                                                                                                | 35% <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> | 35% <a href="#">coinsurance</a>                                                                                                                                | 35% <a href="#">coinsurance</a>                                                  | None                                                                                                                                                                                                                                                                                                  |
|                                                                           | <a href="#">Urgent care</a>                      | \$45 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply                                                                               | \$45 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply | Out-of-network <a href="#">Urgent Care</a> services are covered when <a href="#">network providers</a> 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)               | 35% <a href="#">coinsurance</a>                                                                                                                                | Not Covered                                                                      | Prior authorization may be required. Covered no limit.                                                                                                                                                                                                                                                |
|                                                                           | Physician/surgeon fees                           | 35% <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                              | \$45 <a href="#">copayment</a> /office visit , <a href="#">Deductible</a> does not apply<br><br>35% <a href="#">coinsurance</a> for other outpatient services. | Not Covered                                                                      | Prior authorization may be required. Covered no limit.<br>The cost sharing that displays next to office visit, applies to outpatient office visits only. All other outpatient services may be subject to additional cost sharing. Please refer to the plan policy documents for detailed information. |
|                                                                           | Inpatient services                               | 35% <a href="#">coinsurance</a>                                                                                                                                | Not Covered                                                                      | Prior authorization may be required. Covered no limit.                                                                                                                                                                                                                                                |
| If you are pregnant                                                       | Office visits                                    | No Charge, <a href="#">Deductible</a> does not apply                                                                                                           | Not Covered                                                                      |                                                                                                                                                                                                                                                                                                       |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.amerihhealthcaritasnext.com/content/dam/amerihhealth-caritas/acnext/pdf/de/2026/member/forms/evidence-of-coverage.pdf.coredownload.inline.pdf>

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                      |                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | In Network<br>(You will pay the least) | Out of Network<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                | Childbirth/delivery professional services | 35% <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). Doula services are limited to 3 prenatal visits, up to 90 minutes; attendance through labor and delivery; and 3 postnatal visits, up to 90 minutes. Additional postnatal visits can be authorized if medically necessary - see Specialist Visit for appropriate cost share. |
|                                                                | Childbirth/delivery facility services     | 35% <a href="#">coinsurance</a>        | Not Covered                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 35% <a href="#">coinsurance</a>        | Not Covered                               | 100 visits per benefit period<br>Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                | <a href="#">Rehabilitation services</a>   | 35% <a href="#">coinsurance</a>        | Not Covered                               | 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.<br>Prior authorization may be required.                                                                                                                                                                                                                                                                       |
|                                                                | <a href="#">Habilitation services</a>     | 35% <a href="#">coinsurance</a>        | Not Covered                               | 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.                                                                                                                                                                                                                                                                                                                   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.amerhealthcaritasnext.com/content/dam/amerihealth-caritas/acnext/pdf/de/2026/member/forms/evidence-of-coverage.pdf.coredownload.inline.pdf>

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                    |                                           | Limitations, Exceptions, & Other Important Information                                                  |
|----------------------------------------|-------------------------------------------|------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------|
|                                        |                                           | In Network<br>(You will pay the least)               | Out of Network<br>(You will pay the most) |                                                                                                         |
|                                        |                                           |                                                      |                                           | Prior authorization may be required.                                                                    |
|                                        | <a href="#">Skilled nursing care</a>      | 35% <a href="#">coinsurance</a>                      | Not Covered                               | 120 days per admission<br>Prior authorization may be required.                                          |
|                                        | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a>                      | Not Covered                               | Prior authorization may be required.<br>Covered no limit.                                               |
|                                        | <a href="#">Hospice services</a>          | No Charge                                            | Not Covered                               | Prior authorization may be required.<br>Covered no limit.                                               |
| If your child needs dental or eye care | Children's eye exam                       | No Charge, <a href="#">Deductible</a> does not apply | Not Covered                               | 1 exam per benefit period                                                                               |
|                                        | Children's glasses                        | No Charge, <a href="#">Deductible</a> does not apply | 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                               | None                                                                                                    |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                                 |                                                                                                                                                                                                                                 |                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</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 eye care (Adult)</li> </ul>                                                                  | <ul style="list-style-type: none"> <li>Weight loss programs</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>Abortion 750 dollars per year</li> <li>Bariatric surgery 1 procedures per lifetime</li> <li>Chiropractic care Up to 30 visits per benefit period ;maximum of one visit per day.</li> </ul> | <ul style="list-style-type: none"> <li>Hearing aids 1 wearable item per impaired ear per 3 years</li> <li>Infertility treatment 6 procedures per lifetime</li> <li>Private-duty nursing 240 hours per benefit period</li> </ul> | <ul style="list-style-type: none"> <li>Routine foot care</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 1-866-444-3272 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 Delaware Department of Insurance, 1351 W. North Street, Suite 101, Dover, DE 19904, Phone:

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.amerihealthcaritasnext.com/content/dam/amerihealth-caritas/acnext/pdf/de/2026/member/forms/evidence-of-coverage.pdf.coredownload.inline.pdf>

1-302-674-7300. 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? 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 1-833-590-3300.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-590-3300.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-590-3300.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-590-3300.

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

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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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)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$7,250 |
| ■ <a href="#">Specialist copayment</a>                          | \$110   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%     |
| ■ Other <a href="#">coinsurance</a>                             | 35%     |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$7,250        |
| <a href="#">Copayments</a>        | \$70           |
| <a href="#">Coinsurance</a>       | \$900          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$8,220</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> | \$7,250 |
| ■ <a href="#">Specialist copayment</a>                          | \$110   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%     |
| ■ Other <a href="#">coinsurance</a>                             | 35%     |

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> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$900          |
| <a href="#">Copayments</a>        | \$1,400        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$2,300</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> | \$7,250 |
| ■ <a href="#">Specialist copayment</a>                          | \$110   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%     |
| ■ Other <a href="#">coinsurance</a>                             | 35%     |

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> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,700        |
| <a href="#">Copayments</a>        | \$90           |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,790</b> |

## Notice of Nondiscrimination

AmeriHealth Caritas Next complies with applicable federal civil rights laws and does not discriminate on the basis of race; color; national origin; age; disability; or sex; including sex characteristics, including intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes [consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)]. AmeriHealth Caritas Next does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. AmeriHealth Caritas Next provides free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats. If you need these services, contact the Member Services number on the back of your card. If you believe that AmeriHealth Caritas Next has failed to provide these services or discriminated in another way, you can file a grievance with AmeriHealth Caritas Next, Attention: Member Grievances, P.O. Box 7430, London, KY 40742-7430, fax: **1-833-356-7329**, or email **acaexchange grievance@amerihealthcaritas.com**.

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 at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building Washington, DC 20201, phone: **1-800-368-1019**, TTY: **1-800-537-7697**, Complaint forms are available at **<https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf>**.

## We speak your language

We provide free language services and information to people whose primary language is not English. To talk to an interpreter, call the Member Services number on the back of your card.

Ofrecemos servicios lingüísticos e información sin cargo a las personas cuya lengua materna no es el inglés. Para hablar con un intérprete, llame al número de Servicios al Miembro que figura en el dorso de su tarjeta.

我们为母语非英语的人士提供免费的语言服务及信息。如需与翻译交谈，请拨打您的会员卡背面的会员服务部电话。

Nou bay sèvis ak enfòmasyon gratis pou ede w nan lang pa w si se pa anglè ki lang prensipal ou. Pou pale avèk yon entèprèt, rele nimewo ekip sèvis pou manm yo ki nan do kat ou a.

અમે એવા લોકોને નિ:શુલ્ક ભાષા સેવાઓ અને માહિતી પ્રદાન કરીએ છીએ જેમની પ્રાથમિક ભાષા અંગ્રેજી નથી. દુભાષિયા સાથે વાત કરવા માટે, તમારા કાર્ડની પાછળ આપેલ સભ્ય સેવા નંબર પર કોલ કરો.

Nous fournissons gratuitement des services linguistiques et des informations à ceux dont la langue principale n'est pas l'anglais. Pour communiquer avec un interprète, appelez l'équipe service aux adhérents au numéro indiqué au dos de votre carte.

영어가 주 언어가 아닌 사람들을 위해 무료로 언어 서비스와 정보를 제공합니다. 통역사와 대화하려면 가입자 카드 뒷면에 기재된 가입자 서비스 번호로 연락하십시오.

Offriamo servizi linguistici e informazioni gratuiti per individui la cui lingua principale non è l'inglese. Per parlare con un interprete, chiami il numero dei Servizi per i membri sul retro della sua tessera.

Chúng tôi cung cấp thông tin và các dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh. Để nói chuyện với thông dịch viên, hãy gọi đến số điện thoại của Dịch Vụ Hội Viên ở mặt sau thẻ của quý vị.

Wir bieten Menschen, deren Muttersprache nicht Englisch ist, kostenlose Sprachdienste und Informationen an. Wenn Sie mit einem Dolmetscher oder einer Dolmetscherin sprechen möchten, rufen Sie bitte die Nummer des Mitgliederservice auf der Rückseite Ihrer Karte an.

Nagkakaloob kami ng mga libreng serbisyo sa wika at impormasyon sa mga indibidwal na ang pangunahing wika ay hindi Ingles. Upang makipag-usap sa isang interpreter, tumawag sa numero ng Member Services sa likod ng iyong card.

हम उन लोगों को मुफ्त भाषा सेवाएं और जानकारी प्रदान करते हैं जिनकी प्राथमिक भाषा अंग्रेजी नहीं है। दुभाषिए से बात करने के लिए, अपने कार्ड के पीछे सदस्य सेवाओं के नंबर पर कॉल करें।

ہم زبان کی خدمات اور معلومات ان لوگوں کو مفت فراہم کرتے ہیں جن کی بنیادی زبان انگریزی نہیں ہے۔ کسی مترجم سے بات کرنے کے لیے ممبر سروسز کے نمبر پر کال کریں جو آپ کے کارڈ کی پچھلی طرف درج ہے۔

نقدم خدمات ترجمة مجانية ومعلومات للأشخاص الذين لغتهم الأساسية ليست اللغة الإنجليزية. للتحدث مع مترجم، اتصل برقم خدمات الأعضاء الموجود على ظهر بطاقتك.

ప్రథమ భాష అంగ్లం కాని వారికి మేము ఉచిత భాషా సేవలు మరియు సమాచారాన్ని అందిస్తాము. వ్యాఖ్యాతతో మాట్లాడడానికి, మీ కార్డు వెనుకవైపు ఉన్న మెంబర్ సర్వీసెస్ నంబర్కు కాల్ చేయండి.

We bieden gratis taaldiensten en informatie aan mensen van wie de hoofdtal niet Engels is. Om met een tolk te spreken, belt u het nummer van Ledenservices op de achterkant van uw kaart.