AmeriHealth Caritas
Next
A product of AmeriHealth Caritas Florida, Inc.

# Schedule of Benefits

## AmeriHealth Caritas Next Gold Enhanced + Free 24/7 Preferred Provider PCP/Urgent Virtual Care + No Referrals

Benefit period: From 01/01/2027 through 12/31/2027 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:**<br>- Per Calendar Year<br>- Medical and Drug Combined<br>- Some services do not apply to the deductible, as indicated below. | $1,000/Individual<br>$2,000/Family | Not Covered |
| **Out-of-Pocket Maximum:**<br>- Per Calendar Year<br>- Medical and Drug Combined | $10,000/Individual<br>$20,000/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.

NOTE: Cost sharing waived at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP.

| Benefit | In Network | Out of Network |
|---|---|---|
| **Primary & Specialist Office Visits** | | |
| Primary Care Visit to Treat an Injury or Illness | $35 Copay per visit | Not Covered |
| Specialist Visit | $80 Copay per visit | Not Covered |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | $35 Copay per visit | Not Covered |
| Routine Foot Care | $80 Copay per visit | Not Covered |
| Virtual Care 24/7<br>*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** | | |
| Mammogram | 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†<br>*Combined limit of 35 visits per benefit period for all outpatient therapy and Chiropractic Care.* | $80 Copay per visit | Not Covered |
| Habilitation Services† | $35 Copay per visit | Not Covered |
| Outpatient Rehabilitation Services†<br>*Combined limit of 35 visits per benefit period for all outpatient therapy and Chiropractic Care.* | $35 Copay per visit | Not Covered |
| Rehabilitative Occupational and Rehabilitative Physical Therapy†<br>*Combined limit of 35 visits per benefit period for all outpatient therapy and Chiropractic Care.* | $35 Copay per visit | Not Covered |
| Rehabilitative Speech Therapy†<br>*Combined limit of 35 visits per benefit period for all outpatient therapy and Chiropractic Care.* | $35 Copay per visit | Not Covered |
| Infusion Therapy† | Deductible, then 25% Coinsurance | Not Covered |
| Chemotherapy† | Deductible, then 25% Coinsurance | Not Covered |
| Radiation | Deductible, then 25% Coinsurance | Not Covered |
| **Diagnostic & Imaging** | | |
| Imaging (CT/PET Scans, MRIs)† | Deductible, then 25% Coinsurance | Not Covered |
| Laboratory Outpatient and Professional Services† | Deductible, then 25% Coinsurance | Not Covered |
| X-rays and Diagnostic Imaging | Deductible, then 25% Coinsurance | Not Covered |
| **Outpatient Care** | | |
| Mental/Behavioral Health Office Visits | $35 Copay per visit | Not Covered |
| Mental/Behavioral Health Outpatient Services† | Deductible, then 25% Coinsurance | Not Covered |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)† | Deductible, then 25% Coinsurance | Not Covered |
| Outpatient Surgery Physician/Surgical Services† | Deductible, then 25% Coinsurance | Not Covered |
| Substance Abuse Disorder Office Visits | $35 Copay per visit | Not Covered |
| Substance Abuse Disorder Outpatient Services† | Deductible, then 25% Coinsurance | Not Covered |
| **Inpatient Care** | | |
| Childbirth/Delivery Facility Services† | Deductible, then 25% Coinsurance | Not Covered |
| Coronary Artery Bypass Graft† | Deductible, then 25% Coinsurance | Not Covered |
| Inpatient Hospital Services (e.g., Hospital Stay)† | Deductible, then 25% Coinsurance | Not Covered |

| Benefit | In Network | Out of Network |
|---|---|---|
| Inpatient Physician and Surgical Services† | Deductible, then 25% Coinsurance | Not Covered |
| Mental/Behavioral Health Inpatient Services† | Deductible, then 25% Coinsurance | Not Covered |
| Skilled Nursing Facility†<br>*60 days per benefit period* | Deductible, then 25% Coinsurance | Not Covered |
| Substance Abuse Disorder Inpatient Services† | Deductible, then 25% 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†<br>*20 days per benefit period* | Deductible, then 25% Coinsurance | Not Covered |
| Long-Term/Custodial Nursing Home Care | Not Covered | Not Covered |
| Private-Duty Nursing | Not Covered | Not Covered |
| **Urgent Care** | | |
| Urgent Care Centers or Facilities | $120 Copay per visit | |
| **Emergency Care/Ambulance** | | |
| Emergency Room Services | Deductible, then 25% Coinsurance | |
| Emergency Transportation/Ambulance | Deductible, then 25% Coinsurance | |
| **Durable Medical Equipment and Devices** | | |
| Durable Medical Equipment† | Deductible, then 50% Coinsurance | Not Covered |
| Enteral Formulas† | Deductible, then 25% Coinsurance | Not Covered |
| Orthotic Devices† | Deductible, then 50% Coinsurance | Not Covered |
| Prosthetic Devices† | Deductible, then 50% Coinsurance | Not Covered |
| **Dental Care** | | |
| Accidental Dental† | Deductible, then 25% Coinsurance | Not Covered |
| Basic Dental Care – Child | Not Covered | Not Covered |
| Basic Dental Care – Adult | Not Covered | Not Covered |
| Dental Anesthesia† | Deductible, then 25% Coinsurance | Not Covered |
| Dental Check-Up for Children | Not Covered | Not Covered |
| Major Dental Care – Child | Not Covered | Not Covered |
| Major Dental Care – Adult | Not Covered | Not Covered |
| Orthodontia – Child | Not Covered | Not Covered |
| Orthodontia – Adult | Not Covered | Not Covered |
| Routine Dental Services (Adult) | Not Covered | Not Covered |

| Benefit | In Network | Out of Network |
|---|---|---|
| **Pediatric Vision Services**<br>**Covered through the last day of the month in which a child turns 19** | | |
| Contact Lenses for Children<br>*1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period* | No Charge | Not Covered |
| Eye Glasses for Children<br>*1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period* | No Charge | Not Covered |
| Low Vision Exams and Aids for Children†<br>*1 exam per 5 years* | Deductible, then 25% Coinsurance | Not Covered |
| Routine Eye Exam for Children<br>*1 exam per benefit period* | No Charge | Not Covered |
| **Additional Services** | | |
| Abortion for Which Public Funding is Prohibited | Not Covered | Not Covered |
| Acupuncture | Not Covered | Not Covered |
| Allergy Testing | $80 Copay per visit | Not Covered |
| Bariatric Surgery | Not Covered | Not Covered |
| Bone Marrow Transplant† | Deductible, then 25% Coinsurance | Not Covered |
| Cardiac Rehabilitation†<br>*30 visits per benefit period* | Deductible, then 25% Coinsurance | Not Covered |
| Child Health Supervision | No Charge | Not Covered |
| Congenital Anomaly, including Cleft Lip/Palate† | Deductible, then 25% Coinsurance | Not Covered |
| Contraceptive Injections | Deductible, then 25% Coinsurance | Not Covered |
| Cosmetic Surgery | Not Covered | Not Covered |
| Diabetes Care Management | Deductible, then 25% Coinsurance | Not Covered |
| Diabetes Education | No Charge | Not Covered |
| Dialysis | Deductible, then 25% Coinsurance | Not Covered |
| Doula<br>*1500 dollars per pregnancy* | $80 Copay per visit | Not Covered |
| Hearing Aids | Not Covered | Not Covered |
| Infertility Treatment | Not Covered | Not Covered |
| Mastectomy† | Deductible, then 25% Coinsurance | Not Covered |
| Osteoporosis | Deductible, then 25% Coinsurance | Not Covered |
| Post-Mastectomy Care† | Deductible, then 25% Coinsurance | Not Covered |
| Routine Prenatal and Postnatal Care | No Charge | Not Covered |

| Benefit | In Network | Out of Network |
|---|---|---|
| Pulmonary Rehabilitation†<br>*36 treatments per benefit period* | Deductible, then 25% Coinsurance | Not Covered |
| Reconstructive Surgery† | Deductible, then 25% Coinsurance | Not Covered |
| Routine Eye Exam (Adult) | Not Covered | Not Covered |
| Transplant† | Deductible, then 25% Coinsurance | Not Covered |
| Treatment for Temporomandibular Joint Disorders† | Deductible, then 25% 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<br>(Integrated with Medical Deductible) | $1,000/Individual<br>$2,000/Family | Not Covered |
| Out of Pocket Maximum<br>(Integrated with Medical Out of Pocket Maximum) | $10,000/Individual<br>$20,000/Family | Not Covered |

| Retail Pharmacy (per 30 day supply) | | |
|---|---|---|
| **Tier** | **In Network** | **Out of Network** |
| Preferred Generic Drugs (Tier 1a) | $5 Copay per prescription | Not Covered |
| Non-Preferred Generic Drugs (Tier 1b) | $25 Copay per prescription | Not Covered |
| Preferred Brand Drugs (Tier 2) | $60 Copay per prescription | Not Covered |
| Non-Preferred Brand and Non-Preferred (High Cost) Generic Drugs (Tier 3) | Deductible, then 35% Coinsurance | Not Covered |
| Specialty Drugs (Tier 4a) | Deductible, then 40% Coinsurance | Not Covered |
| Non-Preferred Specialty Drugs (Tier 4b) | Deductible, then 50% Coinsurance | Not Covered |

Prescription Drug Notes:

1. Covers up to a 30-day supply for retail prescriptions; 31–90 day supply for mail order prescriptions.
2. Cost-share shown is per retail prescription per 30-day supply. Mail order cost-share is 2.5 times retail cost.
3. Prior authorization / step therapy may be required.
4. Certain off-label uses of cancer drugs will be covered in accordance with state law.

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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.

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.

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.

Prestamos informações e serviços linguísticos gratuitos a pessoas cujo idioma principal não é o inglês. Para falar com um intérprete, ligue para o número de atendimento ao beneficiário indicado no verso do seu cartão.

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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.

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.

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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.

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.

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Zapewniamy bezpłatne usługi językowe i informacje dla osób, których podstawowym językiem nie jest język angielski. Aby porozmawiać z tłumaczem, należy zadzwonić pod numer działu obsługi klienta podany na odwrocie Pana/i karty.

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