



## **Schedule of Benefits**

**AmeriHealth Caritas Next Gold Copay Focus + \$0 Deductible  
+ Free PCP + 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 plan. Please refer to the Evidence of Coverage (EOC) document for more details on covered 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

An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

### Copayment

A set dollar amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. 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.

### Deductible

The amount you must pay for health care or prescriptions each year before our health plan begins to pay.

### 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.

### Out-of-Pocket Maximum

The most that you pay out of pocket during the calendar year for in-network covered services, including deductibles and any cost sharing. Amounts you pay for your premiums and prescription drugs do not count toward the maximum out-of-pocket amount.

### 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 network provider gets prior authorization from our health 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 |
|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------|
| <b>Deductible:</b><br>- Per Calendar Year<br>- Medical and Drug Combined<br>- Some services do not apply to the deductible, as indicated below. | \$0/Individual<br>\$0/Family          | Not Covered    |
| <b>Out-of-Pocket Maximum:</b><br>- Per Calendar Year<br>- Medical and Drug Combined                                                             | \$9,000/Individual<br>\$18,000/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.

† Prior authorization may be required

| Benefit                                                                                                                                                                                                                                                                     | In Network           | Out of Network |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------|
| <b>Primary &amp; Specialist Office Visits</b>                                                                                                                                                                                                                               |                      |                |
| Primary Care Visit to Treat an Injury or Illness                                                                                                                                                                                                                            | No Charge            | Not Covered    |
| Specialist Visit                                                                                                                                                                                                                                                            | \$35 Copay per visit | Not Covered    |
| Other Practitioner Office Visit (Nurse, Physician Assistant)                                                                                                                                                                                                                | No Charge            | Not Covered    |
| Routine Foot Care                                                                                                                                                                                                                                                           | \$35 Copay per visit | Not Covered    |
| Virtual Care 24/7<br><i>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.</i> | No Charge            | Not Covered    |
| <b>Preventive Care</b>                                                                                                                                                                                                                                                      |                      |                |
| Nutritional Counseling                                                                                                                                                                                                                                                      | No Charge            | Not Covered    |
| Preventive Care/Screening/Immunization                                                                                                                                                                                                                                      | No Charge            | Not Covered    |
| Tubal Ligation                                                                                                                                                                                                                                                              | No Charge            | Not Covered    |
| Well Baby Visits and Care                                                                                                                                                                                                                                                   | No Charge            | Not Covered    |

| Benefit                                                                                                                                                                                                                            | In Network            | Out of Network |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------|
| <b>Therapy</b>                                                                                                                                                                                                                     |                       |                |
| Chiropractic Care†<br><i>Limit of 30 visits per benefit period for Habilitative Chiropractic Care, Physical Therapy, and Occupational Therapy and Rehabilitative Chiropractic Care, Physical Therapy, and Occupational Therapy</i> | \$35 Copay per visit  | Not Covered    |
| Habilitation Services†<br><i>Combined limit of 30 visits per benefit period for Habilitative Chiropractic Care, Physical Therapy, and Occupational Therapy</i>                                                                     | \$35 Copay per visit  | Not Covered    |
| Outpatient Rehabilitation Services†<br><i>Combined limit of 30 visits per benefit period for Rehabilitative Chiropractic Care, Physical Therapy, and Occupational Therapy</i>                                                      | \$35 Copay per visit  | Not Covered    |
| Rehabilitative Occupational and Rehabilitative Physical Therapy†<br><i>Combined limit of 30 visits per benefit period for Rehabilitative Chiropractic Care, Physical Therapy, and Occupational Therapy</i>                         | \$35 Copay per visit  | Not Covered    |
| Rehabilitative Speech Therapy†<br><i>30 visits per benefit period</i>                                                                                                                                                              | \$35 Copay per visit  | Not Covered    |
| Infusion Therapy†                                                                                                                                                                                                                  | 20% Coinsurance       | Not Covered    |
| Chemotherapy†                                                                                                                                                                                                                      | 20% Coinsurance       | Not Covered    |
| Radiation                                                                                                                                                                                                                          | 20% Coinsurance       | Not Covered    |
| <b>Diagnostic &amp; Imaging</b>                                                                                                                                                                                                    |                       |                |
| Imaging (CT/PET Scans, MRIs)†                                                                                                                                                                                                      | \$300 Copay per visit | Not Covered    |
| Laboratory Outpatient and Professional Services†                                                                                                                                                                                   | \$50 Copay per visit  | Not Covered    |
| X-rays and Diagnostic Imaging                                                                                                                                                                                                      | \$65 Copay per visit  | Not Covered    |
| <b>Outpatient Care</b>                                                                                                                                                                                                             |                       |                |
| Mental/Behavioral Health Office Visits                                                                                                                                                                                             | No Charge             | Not Covered    |
| Mental/Behavioral Health Outpatient Services†                                                                                                                                                                                      | \$500 Copay per visit | Not Covered    |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)†                                                                                                                                                                         | \$500 Copay per visit | Not Covered    |
| Outpatient Surgery Physician/Surgical Services†                                                                                                                                                                                    | \$250 Copay per visit | Not Covered    |
| Substance Abuse Disorder Office Visits                                                                                                                                                                                             | No Charge             | Not Covered    |
| Substance Abuse Disorder Outpatient Services†                                                                                                                                                                                      | \$500 Copay per visit | Not Covered    |

| Benefit                                                       | In Network                                                                | Out of Network |
|---------------------------------------------------------------|---------------------------------------------------------------------------|----------------|
| Inpatient Care                                                |                                                                           |                |
| Coronary Artery Bypass Graft†                                 | 20% Coinsurance                                                           | Not Covered    |
| Childbirth/Delivery Facility Services†                        | 20% Coinsurance                                                           | Not Covered    |
| Inpatient Hospital Services (e.g., Hospital Stay)†            | From Day 1 to 3 - \$1,500 Copayment per day<br>Day 4 and after- No Charge | Not Covered    |
| Inpatient Physician and Surgical Services†                    | No Charge                                                                 | Not Covered    |
| Mental/Behavioral Health Inpatient Services†                  | From Day 1 to 3 - \$1,500 Copayment per day<br>Day 4 and after- No Charge | Not Covered    |
| Skilled Nursing Facility†<br>60 days per benefit period       | From Day 1 to 3 - \$1,500 Copayment per day<br>Day 4 and after- No Charge | Not Covered    |
| Substance Abuse Disorder Inpatient Services†                  | From Day 1 to 3 - \$1,500 Copayment per day<br>Day 4 and after- No Charge | Not Covered    |
| Hospice Care                                                  |                                                                           |                |
| Hospice Services†                                             | No Charge                                                                 | Not Covered    |
| Home Health Care, Nursing Home Care, and Private Duty Nursing |                                                                           |                |
| Home Health Care Services†                                    | 20% Coinsurance                                                           | Not Covered    |
| Long-Term/Custodial Nursing Home Care                         | Not Covered                                                               | Not Covered    |
| Private-Duty Nursing†                                         | 20% Coinsurance                                                           | Not Covered    |
| Urgent Care                                                   |                                                                           |                |
| Urgent Care Centers or Facilities                             | \$60 Copay per visit                                                      |                |
| Emergency Care/Ambulance                                      |                                                                           |                |
| Emergency Room Services                                       | \$1,000 Copay per visit                                                   |                |
| Emergency Transportation/Ambulance                            | 20% Coinsurance                                                           |                |
| Durable Medical Equipment and Devices                         |                                                                           |                |
| Durable Medical Equipment†                                    | 50% Coinsurance                                                           | Not Covered    |
| Prosthetic Devices†                                           | 50% Coinsurance                                                           | Not Covered    |
| Dental Care                                                   |                                                                           |                |
| Accidental Dental†                                            | 20% Coinsurance                                                           | Not Covered    |
| Basic Dental Care – Child                                     | Not Covered                                                               | Not Covered    |
| Basic Dental Care – Adult                                     | Not Covered                                                               | Not Covered    |
| Dental Anesthesia†                                            | 20% Coinsurance                                                           | Not Covered    |

| Benefit                                                                                                                                       | In Network           | Out of Network |
|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------|
| 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    |
| <b>Pediatric Vision Services</b><br><b>Covered through the last day of the month in which a child turns 19</b>                                |                      |                |
| Contact Lenses for Children<br><i>1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period</i> | No Charge            | Not Covered    |
| Eye Glasses for Children<br><i>1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period</i>    | No Charge            | Not Covered    |
| Low Vision Exams and Aids for Children†<br><i>1 exam per 5 years</i>                                                                          | 20% Coinsurance      | Not Covered    |
| Routine Eye Exam for Children<br><i>1 exam per benefit period</i>                                                                             | No Charge            | Not Covered    |
| <b>Additional Services</b>                                                                                                                    |                      |                |
| Acupuncture                                                                                                                                   | Not Covered          | Not Covered    |
| Allergy Testing                                                                                                                               | \$35 Copay per visit | Not Covered    |
| Anesthetics                                                                                                                                   | 20% Coinsurance      | Not Covered    |
| Bariatric Surgery†<br><i>1 procedures per lifetime</i>                                                                                        | 50% Coinsurance      | Not Covered    |
| Biofeedback                                                                                                                                   | No Charge            | Not Covered    |
| Blood and Blood Services                                                                                                                      | 20% Coinsurance      | Not Covered    |
| Cardiac Rehabilitation†<br><i>30 visits per benefit period</i>                                                                                | 20% Coinsurance      | Not Covered    |
| Clinical Trials†                                                                                                                              | 20% Coinsurance      | Not Covered    |
| Congenital Anomaly, including Cleft Lip/Palate†                                                                                               | 20% Coinsurance      | Not Covered    |
| Cosmetic Surgery                                                                                                                              | Not Covered          | Not Covered    |
| Diabetes Care Management                                                                                                                      | 20% Coinsurance      | Not Covered    |
| Diabetes Education                                                                                                                            | No Charge            | Not Covered    |
| Dialysis                                                                                                                                      | 20% Coinsurance      | Not Covered    |
| Doula<br><i>1500 dollars per pregnancy</i>                                                                                                    | \$35 Copay per visit | Not Covered    |

| Benefit                                                                                                                                               | In Network      | Out of Network |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------|
| Hearing Aids†<br><i>1 item per impaired ear per 3 years</i>                                                                                           | 20% Coinsurance | Not Covered    |
| Infertility Treatment†<br><i>3 treatments per lifetime</i>                                                                                            | 50% Coinsurance | Not Covered    |
| Male Sterilization                                                                                                                                    | 20% Coinsurance | Not Covered    |
| Organ Donor Search                                                                                                                                    | 20% Coinsurance | Not Covered    |
| Organ Transplant Travel and Lodging†<br><i>Reimbursed based on AmeriHealth Caritas<br/>Next guidelines available from transplant<br/>coordinator.</i> | No Charge       | Not Covered    |
| Orthotic Devices for Positional<br>Plagiocephaly†                                                                                                     | 50% Coinsurance | Not Covered    |
| Routine Prenatal and Postnatal Care                                                                                                                   | No Charge       | Not Covered    |
| Pulmonary Rehabilitation†<br><i>36 treatments per benefit period</i>                                                                                  | 20% Coinsurance | Not Covered    |
| Reconstructive Surgery†                                                                                                                               | 20% Coinsurance | Not Covered    |
| Routine Eye Exam (Adult)                                                                                                                              | Not Covered     | Not Covered    |
| Sexual Dysfunction for Treatment of<br>Organic Disease†                                                                                               | 20% Coinsurance | Not Covered    |
| Transplant†                                                                                                                                           | 20% Coinsurance | Not Covered    |
| Treatment for Temporomandibular Joint<br>Disorders†                                                                                                   | 20% Coinsurance | Not Covered    |
| Weight Loss Programs                                                                                                                                  | Not Covered     | Not Covered    |

# 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)                          | \$0/Individual<br>\$0/Family          | Not Covered    |
| Out of Pocket Maximum<br>(Integrated with Medical Out of<br>Pocket Maximum) | \$9,000/Individual<br>\$18,000/Family | Not Covered    |

| Retail Pharmacy (up to 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<br>(High Cost) Generic Drugs (Tier 3) | 35% Coinsurance             | Not Covered    |
| Specialty Drugs (Tier 4a)                                                   | 40% Coinsurance             | Not Covered    |
| Non-Preferred Specialty Drugs (Tier 4b)                                     | 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 the same as retail prescription at 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.
4. Certain off-label uses of cancer drugs will be covered in accordance with state law.

## 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: Grievances, P.O. Box 7430 London, KY 40742-7430, fax: **1-844-201-6792**, or email [acaexchange grievance@amerihealthcaritas.com](mailto: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。

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.

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

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.

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

Peb muab kev pab cuam txhais lus pub dawb thiab cov ntaub ntawv rau cov neeg uas hom lus ib txwm hais tsis yog lus Askiv. Txhawm rau txuas lus nrog ib tus kws pab txhais lus, hu rau tus npawb xov tooj Pab Cuam Tswv Cuab nyob sab tom qab ntawm koj daim npav.

Мы предоставляем бесплатные языковые услуги и информацию людям, для которых английский не является родным. Чтобы обратиться к переводчику, позвоните по номеру, указанному на обратной стороне вашего удостоверения.

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.



અમે એવા લોકોને નિઃશુલ્ક 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.

យើងផ្តល់ជូនសេវាកម្មភាសា និងព័ត៌មានដោយឥតគិតថ្លៃទៅដល់អ្នកដែលមានភាសាទីមួយមិនមែនជាភាសាអង់គ្លេស ។  
ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ សូមហៅទៅលេខទូរស័ព្ទរបស់សេវាកម្មសមាជិកនៅខាងខ្នងនៃប័ណ្ណរបស់អ្នក ។

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.

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।

ພວກເຮົາໃຫ້ບໍລິການພາສາຟຣີແລະຂໍ້ມູນຂ່າວສານສໍາລັບຜູ້ທີ່ພາສາຂອງທ່ານບໍ່ແມ່ນພາສາອັງກິດ.  
ເພື່ອໂອ້ນລັກບັນຍາຍພາສາ, ໃຫ້ໂທຫາເບີບໍລິການສະມາຊິກຢູ່ດ້ານຫຼັງບັດຂອງທ່ານ.