



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-352-1706 or visit us at www.amerihealthtpa.com. For definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-844-352-1706 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network \$0 person / \$0 family, Out-of-Network \$200 person / \$500 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. In-Network preventive care and services that require a copay . There is no In-Network deductible under this plan .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$500 deductible for prescription drug costs. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	For In-Network providers \$5,720 person / \$11,440 family, for Out-of-Network providers \$5,000 person / \$12,500 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billed charges, health care this plan doesn't cover, and preauthorization penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.amerihealthtpa.com or call: 1-844-352-1706 for a list of In-Network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay per visit	30% coinsurance after deductible	---None---
	Specialist visit	\$20 copay per visit	30% coinsurance after deductible	---None---
	Preventive care/screening/immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Limited to one routine physical per benefit period. Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance after deductible	Some diagnostic services require preauthorization . If preauthorization is not obtained, coverage may be denied.
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance after deductible	
If you need drugs to treat your illness or condition	Generic drugs	Not Covered	Not Covered	Prescription drug benefits not available under the Medical benefit plan .
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance after deductible	Preauthorization is required for some outpatient surgeries. If preauthorization is not obtained, coverage may be denied.
	Physician/surgeon fees	No Charge	30% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	\$125 copay per visit	\$125 copay per visit	If admitted within 24 hours, the copay is waived. Payment at the In-Network level applies only to true medical emergencies & accidental injuries.
	Emergency medical transportation	10% coinsurance	10% coinsurance Deductible waived	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.
	Urgent care	\$20 copay per visit	\$20 copay per visit	---None---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	\$500 copay per stay, then 30% coinsurance after deductible	Preauthorization is required. If preauthorization is not obtained, coverage may be denied.
	Physician/surgeon fees	No Charge	30% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay per visit	30% coinsurance after deductible	Preauthorization may be required. If preauthorization is not obtained, coverage may be denied.
	Inpatient services	No Charge	30% coinsurance after deductible	Preauthorization is required. If preauthorization is not obtained, coverage may be denied.
If you are pregnant	Office visits	\$20 copay per visit	30% coinsurance after deductible	Copay applies to initial visit only.
	Childbirth/delivery professional services	No Charge	30% coinsurance after deductible	Preauthorization is required. If preauthorization is not obtained, coverage may be denied.
	Childbirth/delivery facility services	No Charge	30% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance after deductible	Preauthorization is required. If preauthorization is not obtained, coverage may be denied.
	Rehabilitation services	\$20 copay per visit	30% coinsurance after deductible	Preauthorization is required. If preauthorization is not obtained, coverage may be denied.
	Habilitation services	\$20 copay per visit	30% coinsurance after deductible	
	Skilled nursing care	No Charge	30% coinsurance after deductible	Preauthorization is required. Limited to 120 days In-Network and 60 days Out-of-Network for a combined maximum of 120 days per benefit period. There is a separate \$500 copay for inpatient stay for out-of-network facilities.
	Durable medical equipment	10% coinsurance	30% coinsurance after deductible	Preauthorization is required for all rentals & purchases. If preauthorization is not obtained, coverage may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No Charge	30% coinsurance after deductible	Preauthorization is required. If preauthorization is not obtained, coverage may be denied. There is a separate \$500 copay per inpatient stay for Out-of-Network facilities.
If your child needs dental or eye care	Children's eye exam	\$35 copay per visit	Not Covered	Limited to one exam every 12 months.
	Children's glasses	Not Covered	Not Covered	---None---
	Children's dental check-up	Not Covered	Not Covered	---None---

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Dental care (Adult)
- Long Term Care
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (Pain management only)
- Bariatric surgery (Medical necessity only; [Preauthorization](#) required)
- Chiropractic care (30 visits per benefit period)
- Hearing Aids (Ages 0-15 years only)
- Infertility Treatment ([Preauthorization](#) required)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Outpatient only)
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 1-844-352-1706 or www.amerihelthtpa.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services

AmeriHealth Administrators complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AmeriHealth Administrators does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AmeriHealth Administrators:

- Provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- Provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that AmeriHealth Administrators has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

There are four ways to file a grievance directly with AmeriHealth Administrators:

- by mail: AmeriHealth Administrators,
ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 844-352-1706 (TTY 711);
- by fax: 215-761-0920; or
- by email: AHACivilRightsCoordinator@ahatpa.com.

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Access Services:

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-352-1706 (TTY: 711).

Spanish: ATENCIÓN: Si usted habla inglés, tiene a su disposición servicios de asistencia de idiomas sin costo. Llame al 1-844-352-1706 (TTY: 711).

Chinese: 请注意：如果您说[中文]，则可以免费使用语言协助服务。请致电 1-844-352-1706 (TTY: 711)。

Hmong: LUS CEEB TOOM: Yog tias koj hais LUS HMOOB, ces yuav muaj kev pab cuam txhais lus pub dawb rau koj. Hu rau tus xov tooj 1-844-352-1706 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói [người việt nam], bạn sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí. Gọi 1-844-352-1706 (TTY: 711).

Somali: FIIRO GAAR AH: Haddii aad ku hadashid luuqada Soomaaliga, adeegyada caawinta luuqada, oo bilaash ah, ayaa lagu helayaa. Soo wac 1-844-352-1706 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги переводчика. Позвоните 1-844-352-1706 (TTY: 711).

Arabic: انتبه: إذا كنت تتحدث اللغة العربية، تم توفير خدمات المساعدة اللغوية مجاناً، اتصل بالرقم ١٧٠٦-٣٥٢-٨٤٤-١ (TTY: ٧١١).

French: ATTENTION: Si vous parlez le français, des services d'assistance linguistique gratuits, vous sont proposés. Appelez le 1-844-352-1706 (ATS: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen ein kostenloser Sprachassistent zur Verfügung. Rufen Sie unter der Nummer 1-844-352-1706 (TTY: 711) an.

Amharic: ትኩረት: [አማርኛ] የሚናገሩ ከሆነ ከክፍያ ነፃ የሆነ የቋንቋ አገልግሎት ይገኛል። 1-844-352-1706 (TTY: 711) ላይ ይጻፉ።

Korean: 주의: [한국어]를 사용하는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 1-844-352-1706로 전화해주시요. (TTY: 711).

Lao: ສັງຄົມນີ້: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າ. ໂທ 1-844-352-1706 (TTY: 711).

Tagalog: PANSININ: Kung nagsasalita ka ng Tagalog, libre na available sa iyo ang mga serbisyo sa tulong sa wika. Tumawag sa 1-844-352-1706 (TTY: 711).

Navajo: Áhéhee': T'áá a'nííł nígíí bizaad yádaaltí'í nisin, yá'át'éehá ánída'áł nisin, ákót'éego bee hółó, bizaad yádaaltí'í nisin dah nishlį́, yaaltsoh da t'ááji'ígíí ashkii. 1-844-352-1706 t'áá baa yáshtí'. (TTY: 711).

Khmer: ប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយភាសា [ខ្មែរ] មានផ្តល់សេវាកម្មជំនួយភាសាដោយឥតគិតថ្លៃជូនអ្នក។ ហៅទូរសព្ទទៅលេខ 1-844-352-1706 (TTY: 711)។

Italian: ATTENZIONE: Per coloro che parlano italiano, sono disponibili i servizi di assistenza linguistica gratuiti. Chiamare al numero 1-844-352-1706 (TTY: 711).

Guajarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો ભાષા સહાય સેવાઓ, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-844-352-1706 (TTY: 711) પર કોલ કરો.

Polish: UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług pomocy językowej. Zadzwoń pod numer 1-844-352-1706 (telefon tekstowy: 711).

Creole: ATANSYON: Si ou pale kreyòl, sèvis asistans lang yo gratis, e yo disponib pou ou. Rele nan 1-844-352-1706 (TTY: 711).

Portuguese: ATENÇÃO: Se você fala português, os serviços de assistência linguística, gratuitos, estão disponíveis para você. Ligue 1-844-352-1706 (TTY: 711).

Japanese: 注記: [日本語] 話者向けの無料の言語支援サービスを利用できます。電話 1-844-352-1706 (TTY: 711)。

Farsi: توجه: اگر زبان شما فارسی است، خدمات کمک زبانی، به صورت رایگان در دسترس شما است. با شماره ١٧٠٦-٣٥٢-٨٤٤ تماس بگیرید (TTY: ٧١١).

Urdu: متوجہ ہوں: اگر آپ اردو بولتے ہیں، تو زبان کی معاونت کی خدمات، آپ کے لیے مفت دستیاب ہیں۔ ١٧٠٦-٣٥٢-٨٤٤-١ (TTY: ٧١١) پر کال کریں۔

Hindi: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-352-1706 (TY: 711) पर कॉल करें।

Telugu: ధ్యాన పెట్టండి: మీరు తెలుగు మాట్లాడగలిగితే, భాషా సహాయక సేవలు మీకు ఉచితంగా లభిస్తాయి. 1-844-352-1706 (TTY: 711)కు కాల్ చేయండి.

Swahili: KUMBUKA: Iwapo unazungumza Kiswahili, utapata huduma za usaidizi wa lugha bila malipo. Piga simu kwa 1-844-352-1706 (TTY: 711).

Ojibwe: AMBE: Giishipin wii'wiidookaagooyan ii-noondam Ojibwemowin. ganoozhishinaam 1-844-352-1706 (TTY: 711) Gawain gidaw-diba'anziin.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$20
■ Hospital (facility) no cost sharing	\$0
■ Other no cost sharing	\$0

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$20
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$90

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$20
■ Hospital (facility) no cost sharing	\$0
■ Other no cost sharing	\$0

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$3,500
The total Joe would pay is	\$3,780

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$20
■ Hospital (facility) no cost sharing	\$0
■ Other no cost sharing	\$0

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$410

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