



## **Schedule of Benefits**

### **AmeriHealth Caritas Next Bronze Premier + No Referrals**

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

## About your Schedule of Benefits

This Schedule of Benefits outlines services that may be covered under your 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. | \$3,500/Individual<br>\$7,000/Family  | Not Covered    |
| <b>Out-of-Pocket Maximum:</b><br>- Per Calendar Year<br>- Medical and Drug Combined                                                             | \$9,200/Individual<br>\$18,400/Family | Not Covered    |

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

## Benefit Details

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

| Benefit                                                                                                                                                                                                                                                                     | In Network            | Out of Network |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------|
| <b>Primary &amp; Specialist Office Visits</b>                                                                                                                                                                                                                               |                       |                |
| Other Practitioner Office Visit (Nurse, Physician Assistant)                                                                                                                                                                                                                | \$50 Copay per visit  | Not Covered    |
| Primary Care Visit to Treat an Injury or Illness                                                                                                                                                                                                                            | \$50 Copay per visit  | Not Covered    |
| Routine Foot Care                                                                                                                                                                                                                                                           | \$100 Copay per visit | Not Covered    |
| Specialist Visit                                                                                                                                                                                                                                                            | \$100 Copay per visit | Not Covered    |
| Virtual Care 24/7<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> | Deductible, then 50% Coinsurance | Not Covered    |
| Habilitation Services†<br><i>Combined limit of 30 visits per benefit period for Habilitative Chiropractic Care, Physical Therapy, and Occupational Therapy</i>                                                                     | Deductible, then 50% Coinsurance | 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>                                                      | Deductible, then 50% Coinsurance | 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>                         | \$100 Copay per visit            | Not Covered    |
| Rehabilitative Speech Therapy†<br><i>30 visits per benefit period</i>                                                                                                                                                              | \$100 Copay per visit            | Not Covered    |
| Infusion Therapy†                                                                                                                                                                                                                  | Deductible, then 50% Coinsurance | Not Covered    |
| Chemotherapy†                                                                                                                                                                                                                      | Deductible, then 50% Coinsurance | Not Covered    |
| Radiation                                                                                                                                                                                                                          | Deductible, then 50% Coinsurance | Not Covered    |
| <b>Diagnostic &amp; Imaging</b>                                                                                                                                                                                                    |                                  |                |
| Imaging (CT/PET Scans, MRIs)†                                                                                                                                                                                                      | Deductible, then 50% Coinsurance | Not Covered    |
| Laboratory Outpatient and Professional Services†                                                                                                                                                                                   | Deductible, then 50% Coinsurance | Not Covered    |
| X-rays and Diagnostic Imaging                                                                                                                                                                                                      | Deductible, then 50% Coinsurance | Not Covered    |
| <b>Outpatient Care</b>                                                                                                                                                                                                             |                                  |                |
| Mental/Behavioral Health Outpatient Services†                                                                                                                                                                                      | \$50 Copay per visit             | Not Covered    |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)†                                                                                                                                                                         | Deductible, then 50% Coinsurance | Not Covered    |
| Outpatient Surgery Physician/Surgical Services†                                                                                                                                                                                    | Deductible, then 50% Coinsurance | Not Covered    |
| Substance Abuse Disorder Outpatient Services†                                                                                                                                                                                      | \$50 Copay per visit             | Not Covered    |
| <b>Inpatient Care</b>                                                                                                                                                                                                              |                                  |                |
| Delivery and All Inpatient Services for Maternity Care†                                                                                                                                                                            | Deductible, then 50% Coinsurance | Not Covered    |
| Inpatient Hospital Services (e.g., Hospital Stay)†                                                                                                                                                                                 | Deductible, then 50% Coinsurance | Not Covered    |

| Benefit                                                       | In Network                       | Out of Network |
|---------------------------------------------------------------|----------------------------------|----------------|
| Inpatient Physician and Surgical Services†                    | Deductible, then 50% Coinsurance | Not Covered    |
| Mental/Behavioral Health Inpatient Services†                  | Deductible, then 50% Coinsurance | Not Covered    |
| Skilled Nursing Facility†<br>60 days per benefit period       | Deductible, then 50% Coinsurance | Not Covered    |
| Substance Abuse Disorder Inpatient Services†                  | Deductible, then 50% Coinsurance | Not Covered    |
| Hospice Care                                                  |                                  |                |
| Hospice Services†                                             | Deductible, then No Charge       | Not Covered    |
| Home Health Care, Nursing Home Care, and Private Duty Nursing |                                  |                |
| Home Health Care Services†                                    | Deductible, then 50% Coinsurance | Not Covered    |
| Long-Term/Custodial Nursing Home Care                         | Not Covered                      | Not Covered    |
| Private-Duty Nursing†                                         | Deductible, then 50% Coinsurance | Not Covered    |
| Urgent Care                                                   |                                  |                |
| Urgent Care Centers or Facilities                             | \$75 Copay per visit             |                |
| Emergency Care/Ambulance                                      |                                  |                |
| Emergency Room Services                                       | Deductible, then 50% Coinsurance |                |
| Emergency Transportation/Ambulance                            | Deductible, then 50% Coinsurance |                |
| Durable Medical Equipment and Devices                         |                                  |                |
| Durable Medical Equipment†                                    | Deductible, then 50% Coinsurance | Not Covered    |
| Prosthetic Devices†                                           | Deductible, then 50% Coinsurance | Not Covered    |
| Dental Care                                                   |                                  |                |
| Accidental Dental†                                            | Deductible, then 50% Coinsurance | Not Covered    |
| Basic Dental Care – Child                                     | Not Covered                      | Not Covered    |
| Basic Dental Care – Adult                                     | Not Covered                      | Not Covered    |
| Dental Anesthesia†                                            | Deductible, then 50% 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 |
|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------|
| <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> | Deductible, then 50% Coinsurance | 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>    | Deductible, then 50% Coinsurance | Not Covered    |
| Low Vision Exams and Aids for Children†<br><i>1 exam per 5 years</i>                                                                          | Deductible, then 50% Coinsurance | Not Covered    |
| Routine Eye Exam for Children<br><i>1 exam per benefit period</i>                                                                             | Deductible, then 50% Coinsurance | Not Covered    |
| <b>Additional Services</b>                                                                                                                    |                                  |                |
| Acupuncture                                                                                                                                   | Not Covered                      | Not Covered    |
| Allergy Testing                                                                                                                               | \$100 Copay per visit            | Not Covered    |
| Anesthetics                                                                                                                                   | Deductible, then 50% Coinsurance | Not Covered    |
| Bariatric Surgery†                                                                                                                            | Deductible, then 50% Coinsurance | Not Covered    |
| Biofeedback                                                                                                                                   | \$50 Copay per visit             | Not Covered    |
| Blood and Blood Services                                                                                                                      | Deductible, then 50% Coinsurance | Not Covered    |
| Cardiac Rehabilitation†<br><i>30 visits per benefit period</i>                                                                                | Deductible, then 50% Coinsurance | Not Covered    |
| Clinical Trials†                                                                                                                              | Deductible, then 50% Coinsurance | Not Covered    |
| Congenital Anomaly, including Cleft Lip/Palate†                                                                                               | Deductible, then 50% Coinsurance | Not Covered    |
| Cosmetic Surgery                                                                                                                              | Not Covered                      | Not Covered    |
| Diabetes Care Management                                                                                                                      | Deductible, then 50% Coinsurance | Not Covered    |
| Diabetes Education                                                                                                                            | No Charge                        | Not Covered    |
| Dialysis                                                                                                                                      | Deductible, then 50% Coinsurance | Not Covered    |
| Hearing Aids†<br><i>1 item per impaired ear per 3 years</i>                                                                                   | Deductible, then 50% Coinsurance | Not Covered    |
| Infertility Treatment†<br><i>3 treatments per lifetime</i>                                                                                    | Deductible, then 50% Coinsurance | Not Covered    |
| Male Sterilization                                                                                                                            | Deductible, then 50% Coinsurance | Not Covered    |
| Organ Donor Search                                                                                                                            | Deductible, then 50% Coinsurance | Not Covered    |
| Organ Transplant Travel and Lodging†<br><i>Reimbursed based on AmeriHealth guidelines available from transplant coordinator.</i>              | No Charge                        | Not Covered    |

| Benefit                                                              | In Network                       | Out of Network |
|----------------------------------------------------------------------|----------------------------------|----------------|
| Orthotic Devices for Positional Plagiocephaly†                       | Deductible, then 50% Coinsurance | Not Covered    |
| Prenatal and Postnatal Care                                          | No Charge                        | Not Covered    |
| Pulmonary Rehabilitation†<br><i>36 treatments per benefit period</i> | Deductible, then 50% Coinsurance | Not Covered    |
| Reconstructive Surgery†                                              | Deductible, then 50% Coinsurance | Not Covered    |
| Routine Eye Exam (Adult)                                             | Not Covered                      | Not Covered    |
| Sexual Dysfunction for Treatment of Organic Disease†                 | Deductible, then 50% Coinsurance | Not Covered    |
| Transplant†                                                          | Deductible, then 50% Coinsurance | Not Covered    |
| Treatment for Temporomandibular Joint Disorders†                     | Deductible, then 50% Coinsurance | Not Covered    |
| Weight Loss Programs                                                 | Not Covered                      | Not Covered    |

† Prior authorization may be required

# Prescription Drugs

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

| Prescription Cost Share & Features                                          | In Network                            | Out of Network |
|-----------------------------------------------------------------------------|---------------------------------------|----------------|
| Deductible<br>(Integrated with Medical Deductible)                          | \$3,500/Individual<br>\$7,000/Family  | Not Covered    |
| Out of Pocket Maximum<br>(Integrated with Medical Out of<br>Pocket Maximum) | \$9,200/Individual<br>\$18,400/Family | Not Covered    |

| Retail Pharmacy (up to 30 day supply) |                                  |                |
|---------------------------------------|----------------------------------|----------------|
| Tier                                  | In Network                       | Out of Network |
| Generic Drugs                         | \$30 Copay per prescription      | Not Covered    |
| Preferred Brand Drugs                 | Deductible, then 50% Coinsurance | Not Covered    |
| Non-Preferred Brand Drugs             | Deductible, then 50% Coinsurance | Not Covered    |
| Specialty Drugs                       | 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 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.