Schedule of Benefits

AmeriHealth Caritas Next Silver Deluxe + 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
Deductible: - Per Calendar Year - Medical and Drug Combined - Some services do not apply to the deductible, as indicated below.	$4,300/Individual $8,600/Family	Not Covered
Out-of-Pocket Maximum: - Per Calendar Year - Medical and Drug Combined	$7,350/Individual $14,700/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
Primary & Specialist Office Visits		
Other Practitioner Office Visit (Nurse, Physician Assistant)	$15 Copay per visit	Not Covered
Primary Care Visit to Treat an Injury or Illness	$15 Copay per visit	Not Covered
Routine Foot Care	$30 Copay per visit	Not Covered
Specialist Visit	$30 Copay per visit	Not Covered
Virtual Care 24/7 *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		
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
Therapy		
Chiropractic Care† *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*	Deductible, then 30% Coinsurance	Not Covered
Habilitation Services† *Combined limit of 30 visits per benefit period for Habilitative Chiropractic Care, Physical Therapy, and Occupational Therapy*	Deductible, then 30% Coinsurance	Not Covered
Outpatient Rehabilitation Services† *Combined limit of 30 visits per benefit period for Rehabilitative Chiropractic Care, Physical Therapy, and Occupational Therapy*	Deductible, then 30% Coinsurance	Not Covered
Rehabilitative Occupational and Rehabilitative Physical Therapy† *Combined limit of 30 visits per benefit period for Rehabilitative Chiropractic Care, Physical Therapy, and Occupational Therapy*	Deductible, then 30% Coinsurance	Not Covered
Rehabilitative Speech Therapy† *30 visits per benefit period*	Deductible, then 30% Coinsurance	Not Covered
Infusion Therapy†	Deductible, then 30% Coinsurance	Not Covered
Chemotherapy†	Deductible, then 30% Coinsurance	Not Covered
Radiation	Deductible, then 30% Coinsurance	Not Covered
Diagnostic & Imaging		
Imaging (CT/PET Scans, MRIs)†	Deductible, then 30% Coinsurance	Not Covered
Laboratory Outpatient and Professional Services†	Deductible, then 30% Coinsurance	Not Covered
X-rays and Diagnostic Imaging	Deductible, then 30% Coinsurance	Not Covered
Outpatient Care		
Mental/Behavioral Health Outpatient Services†	$15 Copay per visit	Not Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)†	Deductible, then 30% Coinsurance	Not Covered
Outpatient Surgery Physician/Surgical Services†	Deductible, then 30% Coinsurance	Not Covered
Substance Abuse Disorder Outpatient Services†	$15 Copay per visit	Not Covered
Inpatient Care		
Delivery and All Inpatient Services for Maternity Care†	Deductible, then 30% Coinsurance	Not Covered
Inpatient Hospital Services (e.g., Hospital Stay)†	Deductible, then 30% Coinsurance	Not Covered

Benefit	In Network	Out of Network
Inpatient Physician and Surgical Services†	Deductible, then 30% Coinsurance	Not Covered
Mental/Behavioral Health Inpatient Services†	Deductible, then 30% Coinsurance	Not Covered
Skilled Nursing Facility† *60 days per benefit period*	Deductible, then 30% Coinsurance	Not Covered
Substance Abuse Disorder Inpatient Services†	Deductible, then 30% 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 30% Coinsurance	Not Covered
Long-Term/Custodial Nursing Home Care	Not Covered	Not Covered
Private-Duty Nursing†	Deductible, then 30% Coinsurance	Not Covered
Urgent Care		
Urgent Care Centers or Facilities	$45 Copay per visit	
Emergency Care/Ambulance		
Emergency Room Services	Deductible, then 30% Coinsurance	
Emergency Transportation/Ambulance	Deductible, then 30% 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 30% Coinsurance	Not Covered
Basic Dental Care – Child	Not Covered	Not Covered
Basic Dental Care – Adult	Not Covered	Not Covered
Dental Anesthesia†	Deductible, then 30% 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 **Covered through the last day of the month in which a child turns 19**		
Contact Lenses for Children *1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period*	Deductible, then 30% Coinsurance	Not Covered
Eye Glasses for Children *1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period*	Deductible, then 30% Coinsurance	Not Covered
Low Vision Exams and Aids for Children† *1 exam per 5 years*	Deductible, then 30% Coinsurance	Not Covered
Routine Eye Exam for Children *1 exam per benefit period*	Deductible, then 30% Coinsurance	Not Covered
Additional Services		
Acupuncture	Not Covered	Not Covered
Allergy Testing	$30 Copay per visit	Not Covered
Anesthetics	Deductible, then 30% Coinsurance	Not Covered
Bariatric Surgery†	Deductible, then 50% Coinsurance	Not Covered
Biofeedback	$15 Copay per visit	Not Covered
Blood and Blood Services	Deductible, then 30% Coinsurance	Not Covered
Cardiac Rehabilitation† *30 visits per benefit period*	Deductible, then 30% Coinsurance	Not Covered
Clinical Trials†	Deductible, then 30% Coinsurance	Not Covered
Congenital Anomaly, including Cleft Lip/Palate†	Deductible, then 30% Coinsurance	Not Covered
Cosmetic Surgery	Not Covered	Not Covered
Diabetes Care Management	Deductible, then 30% Coinsurance	Not Covered
Diabetes Education	No Charge	Not Covered
Dialysis	Deductible, then 30% Coinsurance	Not Covered
Hearing Aids† *1 item per impaired ear per 3 years*	Deductible, then 30% Coinsurance	Not Covered
Infertility Treatment† *3 treatments per lifetime*	Deductible, then 50% Coinsurance	Not Covered
Male Sterilization	Deductible, then 30% Coinsurance	Not Covered
Organ Donor Search	Deductible, then 30% Coinsurance	Not Covered
Organ Transplant Travel and Lodging† *Reimbursed based on AmeriHealth guidelines available from transplant coordinator.*	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† *36 treatments per benefit period*	Deductible, then 30% Coinsurance	Not Covered
Reconstructive Surgery†	Deductible, then 30% Coinsurance	Not Covered
Routine Eye Exam (Adult)	Not Covered	Not Covered
Sexual Dysfunction for Treatment of Organic Disease†	Deductible, then 30% Coinsurance	Not Covered
Transplant†	Deductible, then 30% Coinsurance	Not Covered
Treatment for Temporomandibular Joint Disorders†	Deductible, then 30% 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 (Integrated with Medical Deductible)	$4,300/Individual $8,600/Family	Not Covered
Out of Pocket Maximum (Integrated with Medical Out of Pocket Maximum)	$7,350/Individual $14,700/Family	Not Covered

Retail Pharmacy (up to 30 day supply)		
Tier	**In Network**	**Out of Network**
Generic Drugs	$15 Copay per prescription	Not Covered
Preferred Brand Drugs	$100 Copay per prescription	Not Covered
Non-Preferred Brand Drugs	Deductible, then 40% Coinsurance	Not Covered
Specialty Drugs	Deductible, then 40% 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.