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 **$500** person / **$1,000** 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 other services as indicated in this SBC. There is no In-Network deductible for 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. **$1,000** for In-Network infertility services. 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 **$2,000** person / **$5,000** family, for Out-of-Network providers **$4,000** person / **$8,000** 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	$15 copay per visit	30% coinsurance after deductible	---None---
	Specialist visit	$25 copay per visit	30% coinsurance after deductible	Chiropractor: Limited to 30 visits per benefit period.
	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. One routine physical per benefit period.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay per visit for X-rays. No Charge for blood work.	30% coinsurance after deductible	---None---
	Imaging (CT/PET scans, MRIs)	$25 copay per scan	30% coinsurance after deductible	Preauthorization is required for some imaging services. Coverage may be denied if preauthorization is not obtained.
If you need drugs to treat your illness or condition	Generic drugs	See separate prescription drug plan SBC	See separate prescription drug plan SBC	See separate prescription drug plan SBC.
	Preferred brand drugs			
	Non-preferred drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance after deductible	---None---
	Physician/surgeon fees	No Charge	30% coinsurance after deductible	---None---
If you need immediate medical attention	Emergency room care	$75 copay per visit	$75 copay per visit Deductible waived	If admitted within 24 hours, the copay is waived. Payment at the In-Network level applies only to true medical emergencies and 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	$25 copay per visit	$25 copay per visit Deductible waived	---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	30% coinsurance after deductible	Preauthorization is required. Coverage may be denied if preauthorization is not obtained.
	Physician/surgeon fees	No Charge	30% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit	30% coinsurance after deductible	Substance use disorder: No Charge. Some specialty outpatient services require preauthorization. Coverage may be denied if preauthorization is not obtained.
	Inpatient services	No Charge	30% coinsurance after deductible	Preauthorization is required. Coverage may be denied if preauthorization is not obtained.
If you are pregnant	Office visits	$25 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. Coverage may be denied if preauthorization is not obtained.
	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. Coverage may be denied if preauthorization is not obtained.
	Rehabilitation services	$25 copay per visit	30% coinsurance after deductible	Preauthorization may be required for some therapies. Coverage may be denied if preauthorization is not obtained.
	Habilitation services	$25 copay per visit	30% coinsurance after deductible	
	Skilled nursing care	No Charge	30% coinsurance after deductible	Limit of 120 days per benefit period, combined In-Network and Out-of-Network. Preauthorization is required. Coverage may be denied if preauthorization is not obtained.
	Durable medical equipment	10% coinsurance	30% coinsurance after deductible	Preauthorization is required for all rentals and some purchases. Coverage may be denied if preauthorization is not obtained.
	Hospice services	No Charge	30% coinsurance after deductible	Preauthorization is required. Coverage may be denied if preauthorization is not obtained.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam every 12 months.
	Children's glasses	No Charge	No Charge	Limited to $100 allowance every 24 months.
	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
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (for pain management only)
- Bariatric surgery (requires preauthorization)
- Chiropractic care (30 visits per benefit period)
- Hearing Aids (covered for members age 15 or younger only, maximums apply)
- Infertility Treatment (requires preauthorization. $1,000 deductible. In-Network coverage only)
- Non-emergency care when traveling outside the U.S. (subject to deductible/coinsurance and balance billing)
- Routine eye care (Adult)

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.amerihealthtpa.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 laguu 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 مجانًا، اتصل بالرقم ١-٨٤٤-٣٥٢-١٧٠٦ (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 አገልግሎቶች በነጻ ያገኛሉ። 1-844-352-1706 (TTY: 711) ላይ ይደውሉ።

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

Lao: ສິ່ງທີ່ຄວນຈື່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. 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 ał'níił nigií bizaad yádaalłti'í nisin, yá'át'ééhá ánída'áł nisin, ákót'éego bee hóló, bizaad yádaalłti'í nisin dah nishłį, yaałtsoh da t'ááji'ígíí ashkii. 1-844-352-1706 t'áá baa yáshti'. (TTY: 711).

Khmer: ប្រុងប្រយ័ត្ន៖ ប្រសិនបើអ្នកនិយាយភាសា [ខ្មែរ] មានផ្តល់សេវាកម្មជំនួយភាសាដែលឥតគិតថ្លៃជូនអ្នក។ 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 નિઃશુલ્ક ઉપલબ્ધ છે. 1-844-352-1706 (TTY: 711) પર કૉલ 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 ١-٨٤٤-٣٥٢-١٧٠٦ تماس بگیرید (TTY: ٧١١).

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

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

Telugu: ధ్యాస 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 ji-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	$25
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$470**

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	$25
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$80
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$3,880**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$25
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$100
What isn't covered	
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.