Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Kingsway Regional School District: EPO 30/50

Coverage Period: 07/01/2023 - 06/30/2024
Coverage for: Individual + Family | **Plan Type:** PPO

⚠ **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.amerihealth.com/tpa. 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?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. There is no 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network providers **$3,000** person / **$6,000** family, for Out-of-Network providers: **Not Covered**.	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.amerihealth.com/tpa 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	$30 copay per visit	Not Covered	---None---
	Specialist visit	$50 copay per visit	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	---None---
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Preauthorization is required for some imaging services. Services could be denied coverage if preauthorization is not obtained when required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$8 copay per fill retail $8 copay per fill mail order	Not Covered	Up to 90-day supply for retail and mail order. Prescription drug out-of-pocket limit: $2,500 person / $5,000 family. Administered by Express Scripts.
	Preferred brand drugs	$18 copay per fill retail $8 copay per fill mail order	Not Covered	
	Non-preferred drugs	$18 copay per fill retail $8 copay per fill mail order	Not Covered	
	Specialty drugs	$18 copay per fill retail	Not Covered	Up to 30-day supply for retail and mail order. Prescription drug out-of-pocket limit: $2,500 person / $5,000 family. Administered by Express Scripts.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay per visit	Not Covered	Preauthorization is required for some outpatient surgeries. Services could be denied coverage if preauthorization is not obtained when required.
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate medical attention	Emergency room care	$100 copay per visit	$100 copay per visit	Copay is waived if you are admitted to the hospital.
	Emergency medical transportation	No Charge	No Charge	---None---
	Urgent care	$50 copay per visit	$50 copay per visit	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per day up to 5 copays per admission	Not Covered	Preauthorization is required. Services could be denied coverage if preauthorization is not obtained.
	Physician/surgeon fees	No Charge	Not Covered	

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay per visit	Not Covered	Substance use disorder: Preauthorization is required. Services could be denied coverage if preauthorization is not obtained.
	Inpatient services	$500 copay per day up to 5 copays per admission	Not Covered	Preauthorization is required. Services could be denied coverage if preauthorization is not obtained.
If you are pregnant	Office visits	$30 copay for initial visit only	Not Covered	---None---
	Childbirth/delivery professional services	No Charge	Not Covered	Preauthorization is required. Services could be denied coverage if preauthorization is not obtained.
	Childbirth/delivery facility services	$500 copay per day up to 5 copays per admission	Not Covered	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Preauthorization is required. Services could be denied coverage if preauthorization is not obtained.
	Rehabilitation services	$50 copay per visit	Not Covered	Preauthorization may be required and visit limits may apply for some therapies. Services could be denied coverage if preauthorization is not obtained when required.
	Habilitation services	$50 copay per visit	Not Covered	
	Skilled nursing care	No Charge	Not Covered	Limit of 120 days per benefit period. Preauthorization is required. Services could be denied coverage if preauthorization is not obtained.
	Durable medical equipment	50% coinsurance	Not Covered	Preauthorization is required for all rentals and some purchases. Services could be denied coverage if preauthorization is not obtained when required.
	Hospice services	No Charge	Not Covered	Preauthorization is required. Services could be denied coverage 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 every 12 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.)		
• Acupuncture	• Hearing Aids	• Private-duty nursing (Inpatient)
• Cosmetic surgery	• Long Term Care	• Routine foot care
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (Requires preauthorization)	• Infertility Treatment (Requires preauthorization)	• Routine eye care (Adult) (One exam and $100 in hardware per 12 months)
• Chiropractic care (30 visits per benefit period)		

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.amerihealth.com/tpa. 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:

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-352-1706 (TTY: 711).

注意：如果您使用简体中文，您可以免费获得语言协助服务。请致电1-844-352-1706。

LƯU Ý: Nếu quý vị nói tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-844-352-1706.

ВНИМАНИЕ: Если вы говорите по-русски, вам предлагаются бесплатные услуги переводчика. Позвоните по телефону 1-844-352-1706.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-352-1706.

알림: 한국어 통역서비스가 필요한 분은 1-844-352-1706로 전화하십시오. 통역서비스를 무료로 받으실 수 있습니다.

ATTENZIONE: se parla italiano, sono disponibili per lei servizi di assistenza linguistica gratuiti. Contatti il numero 1-844-352-1706.

انتباه: إذا كنت تتحدث العربية فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على الرقم: 1706-352-844-1.

ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le 1-844-352-1706.

HINWEIS: Wenn Sie Deutsch sprechen, steht Ihnen über Language Assistance Services ein Dolmetscher kostenlos zur Verfügung. Wählen Sie 1-844-352-1706.

ધ્યાન આપો : જો તમે ગુજરાતી બોલી શકતા હો, તો તમારા માટે ભાષા સહાય સેવાઓ, વિના મૂલ્યે, ઉપલબ્ધ છે. 1-844-352-1706 પર કૉલ કરો.

UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-352-1706.

ATANSYON: Si ou pale kreyòl ayisyen, gen asistans ak lang disponib pou ou gratis. Rele 1-844-352-1706.

ចំណាំៈ ប្រសិនបើអ្នកនិយាយភាសា មន-ខ្មែរ ប្រទេសខ្មែរ សេវាជំនួយភាសាដែលឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ 1-844-352-1706។

ATENÇÃO: se você fala português, serviços de assistência a idioma estão disponíveis gratuitamente para você. Ligue para 1-844-352-1706.

BAA !KON&N&ZIN: Din4 bizaad bee y1n7[ti'go, ata' hane' bee 1k1 i'iilyeed t'11 j77k'e bee n1 ah00t'i'. Koj8' hod77lnih 1-844-352-1706.

PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong para sa wika nang walang bayad. Tumawag sa 1-844-352-1706.

注意：日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。1-844-352-1706にお電話ください。

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان، به رایگان در اختیار شما می باشد. با شماره 1706-352-844-1تماس بگیرید.

——————————————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)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The plan's overall deductible $0	■ The plan's overall deductible $0	■ The plan's overall deductible $0
■ Specialist copayment $50	■ Specialist copayment $50	■ Specialist copayment $50
■ Hospital (facility) copayment $500	■ Hospital (facility) copayment $500	■ Hospital (facility) copayment $500
■ Other no cost sharing $0	■ Other 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*)

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*)

This EXAMPLE event includes services like:

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

Total Example Cost	$12,700

Total Example Cost	$5,600

Total Example Cost	$2,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.