**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, visit https://ambetter.SuperiorHealthPlan.com/2019-brochures.html, or call 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989). For general 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 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989) to request a copy.

| Important Questions | Answers | Why This Matters: |
| --- | --- | --- |
| **What is the overall deductible?** | $6,000 individual/$12,000 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. preventive services, primary care, specialist, and urgent care office visits, generic and preferred brand drugs are covered before you meet your deductible. | 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 network providers: $7,900 individual/$15,800 family. No, for non-network providers. | 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?** | Premium, balance-billing charges, and health care this plan doesn't cover. | 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 Find a Provider or call 1-877-687-1196 for a list of 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'scharge 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. |

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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<br>Network Provider (You will pay the least) | What You Will Pay<br>Out-of-Network Provider (You will pay the most) | Limitation, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 Copay/visit; deductible does not apply | Not covered | -----None----- |
| | Specialist visit | $60 Copay/visit; deductible does not apply | Not covered | -----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 needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $30 Copay for laboratory outpatient & professional services; deductible does not apply; 40% Coinsurance for x-ray and diagnostic imaging | Not covered | Prior authorization may be required. Failure to obtain prior authorization for any service that requires prior authorization may result in reduction of benefits. See your policy for more details. |
| | Imaging (CT/PET scans, MRIs) | 40% Coinsurance | Not covered | Prior authorization may be required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitation, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br>More information about prescription drug coverage is available at Preferred Drug List. | Generic drugs (Tier 1) | Retail: $20 Copay/prescription; Mail order: $60 Copay/prescription; deductible does not apply | Not covered | Prescription drugs are provided up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount. |
| | Preferred brand drugs (Tier 2) | Retail: $50 Copay/prescription; Mail order: $150 Copay/prescription; deductible does not apply | Not covered | Prior authorization may be required. Prescription drugs are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount. |
| | Non-preferred brand drugs (Tier 3) | 40% Coinsurance | Not covered | Prior authorization may be required. Prescription drugs are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount. |
| | Specialty drugs (Tier 4) | 40% Coinsurance | Not covered | Prior authorization may be required. Prescription drugs are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 40% Coinsurance | Not covered | Prior authorization may be required. |
| | Physician/surgeon fees | 40% Coinsurance | Not covered | Prior authorization may be required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitation, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need immediate medical attention | Emergency room care | 40% Coinsurance | 40% Coinsurance | -----None----- |
| | Emergency Medical transportation | 40% Coinsurance | 40% Coinsurance | -----None----- |
| | Urgent Care | $100 Copay/visit; deductible does not apply | Not covered | -----None----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 40% Coinsurance | Not covered | Prior authorization may be required. |
| | Physician/surgeon fees | 40% Coinsurance | Not covered | Prior authorization may be required. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $30 Copay /office visit; deductible does not apply; 40% Coinsurance for all other services | Not covered | Prior authorization may be required. (PCP and other practitioner visits do not require prior authorization) |
| | Inpatient services | 40% Coinsurance | Not covered | Prior authorization may be required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitation, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | $30 Copay/visit; deductible does not apply | Not covered | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 40% Coinsurance | Not covered | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery facility services | 40% Coinsurance | Not covered | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |

| Common Medical Event | Services You May Need | What You Will Pay: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | Limitation, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you need help recovering or have other special health needs | Home health care | 40% Coinsurance | Not covered | Prior authorization may be required. 60 Visits per year. |
| | Rehabilitation services | 40% Coinsurance | Not covered | 35 visits per year, combined with chiropractic care (visit limit does not apply to treatment or care determined to be medically necessary as a result of and related to an acquired brain injury or to treatment of developmental delays). |
| | Habilitation services | 40% Coinsurance | Not covered | 35 visits per year (visit limit does not apply to treatment of developmental delays). |
| | Skilled nursing care | 40% Coinsurance | Not covered | Prior authorization may be required. 25 days per year. |
| | Durable medical equipment | 40% Coinsurance | Not covered | Prior authorization may be required. |
| | Hospice services | 40% Coinsurance | Not covered | Prior authorization may be required. |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | 1 Visit per year. |
| | Children's glasses | No charge | Not covered | 1 Item per year. |
| | 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 documentation for more information and a list of any other excluded services.)

- Abortion (Except when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Non-emergency care when traveling outside the U.S.
- Long-term care
- Private-duty nursing
- 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.) | | |
|---|---|---|
| • Chiropractic care (Limited to 35 specialist visits per year, combined with rehabilitation services) | • Hearing aids (Two items per three years)<br>• Infertility treatment (Coverage for the diagnosis of infertility only) | • Routine foot care (For diabetes treatment) |

**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: Ambetter from Superior HealthPlan at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989); Texas Department of Insurance, 333 Guadalupe, Austin, TX 78701, Phone No. (800) 578-4677. 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 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: Texas Department of Insurance, 333 Guadalupe, Austin, TX 78701, Phone No. (800) 578-4677.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989)
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989)
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989)
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989)

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 prenatal care and a hospital delivery)

- The plan's overall deductible $6,000
- Specialist copayment $60
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

**This EXAMPLE even includes services like:**
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery facility Services
Diagnostic test (ultrasounds and blood work)
Specialist visit (anesthesia)

| **Total Example Cost** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| Cost Sharing | |
|---|---|
| Deductibles | $3,300 |
| Copayments | $900 |
| Coinsurance | $3,600 |
| What isn't covered | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,860** |

### Managing Joe's type 2 Diabetes

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

- The plan's overall deductible $6,000
- Specialist copayment $60
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

**This EXAMPLE even includes services like:**
Primary care physician office visits (includes disease education)
Diagnostic tests (blood work)
Prescription Drugs
Durable medical equipment (glucose meter)

| **Total Example Cost** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| Cost Sharing | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $2,100 |
| Coinsurance | $700 |
| What isn't covered | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$3,860** |

### Mia's Simple Fracture

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

- The plan's overall deductible $6,000
- Specialist copayment $60
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

**This EXAMPLE even includes services like:**
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (Physical therapy)

| **Total Example Cost** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| Cost Sharing | |
|---|---|
| Deductibles | $1,800 |
| Copayments | $50 |
| Coinsurance | $50 |
| What isn't covered | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,900** |

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

## Statement of Non-Discrimination

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

Ambetter from Superior HealthPlan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ambetter from Superior HealthPlan at 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989).

If you believe that Ambetter from Superior HealthPlan 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: Superior HealthPlan Complaint Department, 5900 E Ben White Blvd., Austin, TX 78741, 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989), Fax 1-866-683-5369. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Superior HealthPlan 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.

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| | |
|---|---|
| **Spanish:** | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Superior HealthPlan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989). |
| **Vietnamese:** | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Superior HealthPlan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989). |
| **Chinese:** | 如果您，或是您正在協助的對象，有關於 Ambetter from Superior HealthPlan 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)。 |
| **Korean:** | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Superior HealthPlan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) 로 전화하십시오. |
| **Arabic:** | إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Superior HealthPlan ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989). |
| **Urdu:** | اگر Ambetter from Superior HealthPlan کے بارے میں آپ، یا جن کی آپ مدد کررہے ہیں ان کے سوالات ہوں تو، آپ کو بلامعاوضہ اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے، 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)، پر کل کریں۔ |
| **Tagalog:** | Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Superior HealthPlan, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989). |
| **French:** | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Superior HealthPlan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989). |
| **Hindi:** | आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Superior HealthPlan के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) पर कॉल करें। |
| **Persian:** | اگر شما، يا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Superior HealthPlan داريد، از اين حق برخورداريد که کمک و اطلاعات را بصورت رايگان به زبان خود دريافت کنيد. براي صحبت کردن با مترجم با شماره 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) تماس بگيريد. |
| **German:** | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Superior HealthPlan hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) an. |
| **Gujarati:** | જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from Superior HealthPlan વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) ઉપર કૉલ કરો. |
| **Russian:** | В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Superior HealthPlan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989). |
| **Japanese:** | Ambetter from Superior HealthPlan について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) までお電話ください。 |
| **Laotian:** | ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ ມີຄໍາຖາມກ່ຽວກັບ Ambetter from Superior HealthPlan, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989). |

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