



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.buckeyehealthplan.com/2023-brochures.html>, or call 1-877-687-1189 (TTY/TDD 1-877-941-9236). 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 1-877-687-1189 (TTY/TDD 1-877-941-9236) to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                             | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$750 individual / \$1,500 family.                                                                                                                                                                                                                                                  | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> services, primary care, <a href="#">specialist</a> , and <a href="#">urgent care</a> office visits, children's eye exam and glasses, lab-work, generic and preferred brand drugs are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                                                 | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> : \$7,500 individual / \$15,000 family. Not applicable for <a href="#">out-of-network providers</a> .                                                                                                                                         | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                                                                                                                                        | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://ambetter.buckeyehealthplan.com/findadoc">https://ambetter.buckeyehealthplan.com/findadoc</a> or call 1-877-687-1189 (TTY/TDD 1-877-941-9236) for a list of <a href="#">network providers</a> .                                                            | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

|                                                                              |     |                                                                                            |
|------------------------------------------------------------------------------|-----|--------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No. | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |
|------------------------------------------------------------------------------|-----|--------------------------------------------------------------------------------------------|

 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                                                                                                                                                                                                                                                             |
|------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                        | Network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                              | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                    |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | \$35 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                             | Not covered                                        | Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, <a href="#">providers</a> covered in full, <a href="#">deductible</a> does not apply.                                                                                                                                        |
|                                                                        | <a href="#">Specialist</a> visit                       | \$55 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                             | Not covered                                        | Covered No Limit.                                                                                                                                                                                                                                                                                                  |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                                                      | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                                                          |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)    | \$35 <a href="#">Copay</a> / test; <a href="#">deductible</a> does not apply for laboratory & professional services<br>35% <a href="#">Coinsurance</a> for x-ray & diagnostic imaging<br>35% <a href="#">Coinsurance</a> for laboratory & professional services and x-ray & diagnostic imaging at other places of service | Not covered                                        | Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility.<br><br>Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details. |
|                                                                        | Imaging (CT/PET scans, MRIs)                           | 35% <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                                                           | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                             |

| Common Medical Event                                                                                                                                                                                                                                                                                                          | Services You May Need                            | What You Will Pay                                                                                                                                                                                                     |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                               |                                                  | Network Provider<br>(You will pay the least)                                                                                                                                                                          | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="https://ambetter.buckeyehealthplan.com/2023formulary">prescription drug coverage</a> is available at <a href="https://ambetter.buckeyehealthplan.com/2023formulary">https://ambetter.buckeyehealthplan.com/2023formulary</a> . | Generic drugs (Tier 1)                           | Preferred Generic Retail: \$5 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply<br>Generic Retail: \$15 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply | Not covered                                        | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <a href="#">cost-sharing</a> amount.                                                                                                    |
|                                                                                                                                                                                                                                                                                                                               | Preferred brand drugs (Tier 2)                   | Retail: \$60 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply                                                                                                                          | Not covered                                        | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <a href="#">cost-sharing</a> amount.                                                                                                    |
|                                                                                                                                                                                                                                                                                                                               | Non-preferred brand drugs (Tier 3)               | Retail: 50% <a href="#">Coinsurance</a>                                                                                                                                                                               | Not covered                                        | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 30 days through mail order.                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                               | <a href="#">Specialty drugs</a> (Tier 4)         | Retail: 50% <a href="#">Coinsurance</a>                                                                                                                                                                               | Not covered                                        |                                                                                                                                                                                                                                                                                                                                |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                                         | Facility fee (e.g., ambulatory surgery center)   | 35% <a href="#">Coinsurance</a>                                                                                                                                                                                       | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                               | Physician/surgeon fees                           | 35% <a href="#">Coinsurance</a>                                                                                                                                                                                       | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                                                                                | <a href="#">Emergency room care</a>              | 35% <a href="#">Coinsurance</a>                                                                                                                                                                                       | 35% <a href="#">Coinsurance</a>                    | Covered No Limit.                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                               | <a href="#">Emergency medical transportation</a> | 35% <a href="#">Coinsurance</a>                                                                                                                                                                                       | 35% <a href="#">Coinsurance</a>                    | Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. If you receive service from an out of <a href="#">network</a> ground/water ambulance <a href="#">provider</a> , you may be subject to <a href="#">balance billing</a> . |
|                                                                                                                                                                                                                                                                                                                               | <a href="#">Urgent care</a>                      | \$35 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                         | Not covered                                        | Covered No Limit.                                                                                                                                                                                                                                                                                                              |
| <b>If you have a hospital stay</b>                                                                                                                                                                                                                                                                                            | Facility fee (e.g., hospital room)               | 35% <a href="#">Coinsurance</a>                                                                                                                                                                                       | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                               | Physician/surgeon fees                           | 35% <a href="#">Coinsurance</a>                                                                                                                                                                                       | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                                                                                                   |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | Network Provider<br>(You will pay the least)                                                                                                        | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$35 <a href="#">Copay</a> / office visit; <a href="#">deductible</a> does not apply; 35% <a href="#">Coinsurance</a> for other outpatient services | Not covered                                        | Prior authorization may be required. Covered No Limit. ( <a href="#">Primary care provider</a> (PCP) and other practitioner visits do not require prior authorization).                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                  | Inpatient services                        | 35% <a href="#">Coinsurance</a>                                                                                                                     | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>If you are pregnant</b>                                                       | Office visits                             | \$35 <a href="#">Copay</a> / visit; <a href="#">deductible</a> 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. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> , such as routine pre-natal and post-natal <a href="#">screenings</a> . Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">deductible</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                                  | Childbirth/delivery professional services | 35% <a href="#">Coinsurance</a>                                                                                                                     | Not covered                                        | Prior authorization may be required. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).                                                                                                                                                                                |
|                                                                                  | Childbirth/delivery facility services     | 35% <a href="#">Coinsurance</a>                                                                                                                     | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 35% <a href="#">Coinsurance</a>                                                                                                                     | Not covered                                        | Prior authorization may be required. Limited to 100 visits per year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                  | <a href="#">Rehabilitation services</a>   | Outpatient: 35% <a href="#">Coinsurance</a><br>Inpatient: 35% <a href="#">Coinsurance</a>                                                           | Not covered                                        | Outpatient: Prior authorization may be required. Rehabilitation Therapy: Speech, Occupational, and Physical Therapy limited to 20 visits each, Cardiac limited to 36 visits and Pulmonary limited to 20 visits per year. Services may be used for Intensive Day Rehabilitation. Note: Limits do not apply                                                                                                                                                                                                                                     |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                                                         |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                            |
|----------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                           | Network Provider<br>(You will pay the least)                                              | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                   |
|                                        |                                           |                                                                                           |                                                    | when provided for a mental health/substance use disorder diagnosis.<br>Inpatient: Prior authorization may be required. Limited to 60 Days Per Year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. |
|                                        | <a href="#">Habilitation services</a>     | Outpatient: 35% <a href="#">Coinsurance</a><br>Inpatient: 35% <a href="#">Coinsurance</a> | Not covered                                        | Outpatient: Prior authorization may be required. Covered No Limit.<br>Inpatient: Prior authorization may be required. Limited to 60 Days Per Year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.  |
|                                        | <a href="#">Skilled nursing care</a>      | 35% <a href="#">Coinsurance</a>                                                           | Not covered                                        | Prior authorization may be required. Limited to 90 days per year in a facility.                                                                                                                                                                   |
|                                        | <a href="#">Durable medical equipment</a> | 35% <a href="#">Coinsurance</a>                                                           | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                            |
|                                        | <a href="#">Hospice services</a>          | 35% <a href="#">Coinsurance</a>                                                           | Not covered                                        | Prior authorization may be required. Covered no limit. Respite Care limited to 14 days per calendar year. Covered as part of <a href="#">hospice services</a> only.                                                                               |
| If your child needs dental or eye care | Children's eye exam                       | No charge; <a href="#">deductible</a> does not apply                                      | Not covered                                        | Limited to 1 visit per year.                                                                                                                                                                                                                      |
|                                        | Children's glasses                        | No charge; <a href="#">deductible</a> does not apply                                      | Not covered                                        | Limited to 1 item per year.                                                                                                                                                                                                                       |
|                                        | Children's dental check-up                | Not covered                                                                               | Not covered                                        | -----None-----                                                                                                                                                                                                                                    |

## Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                          |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Abortion (Except in cases when the life of the mother is endangered)</li><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li></ul>                        | <ul style="list-style-type: none"><li>• Dental care (Children)</li><li>• Hearing aids</li><li>• Infertility treatment (Not Covered. Note: Coverage is available for diagnosis and services required to correct underlying medical causes of infertility.)</li></ul> | <ul style="list-style-type: none"><li>• Long-Term Care (Long Term Acute Care is a covered benefit. Long Term Nursing Care/ Custodial Care is not a covered benefit.)</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Weight loss programs</li></ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                                               |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                            |
| <ul style="list-style-type: none"><li>• Chiropractic care (Limited to 12 visits per year)</li><li>• Dental care (Adult-visit &amp; item limits apply per year. \$1,000 annual dollar limit per year per person.)</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing (Limited to 90 visits per year)</li><li>• Routine eye care (Adult-one visit &amp; one item per year. Dollar allowance applies to hardware.)</li></ul>                                                  | <ul style="list-style-type: none"><li>• Routine foot care</li></ul>                                                                                                                                                                                                        |

**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 Buckeye Health [Plan](#) at 1-877-687-1189 (TTY/TDD 1-877-941-9236); Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300 Columbus, Ohio 43215, Phone No. 1-800-686-1526. 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](http://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: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300 Columbus, Ohio 43215, Phone No. 1-800-686-1526.

**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 Minimum Value Standards? Not Applicable.**

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 1-877-687-1189 (TTY/TDD 1-877-941-9236).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-687-1189 (TTY/TDD 1-877-941-9236).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-687-1189 (TTY/TDD 1-877-941-9236).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-687-1189 (TTY/TDD 1-877-941-9236).

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$750 |
| ■ <a href="#">Specialist copayment</a>                          | \$55  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%   |
| ■ Other <a href="#">coinsurance</a>                             | 35%   |

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                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$750   |
| <a href="#">Copayments</a>  | \$500   |
| <a href="#">Coinsurance</a> | \$2,800 |
| What isn't covered          |         |
| Limits or exclusions        | \$60    |
| The total Peg would pay is  | \$4,110 |

### Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$750 |
| ■ <a href="#">Specialist copayment</a>                          | \$55  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%   |
| ■ Other <a href="#">coinsurance</a>                             | 35%   |

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                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$750   |
| <a href="#">Copayments</a>  | \$1,400 |
| <a href="#">Coinsurance</a> | \$10    |
| What isn't covered          |         |
| Limits or exclusions        | \$20    |
| The total Joe would pay is  | \$2,180 |

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$750 |
| ■ <a href="#">Specialist copayment</a>                          | \$55  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%   |
| ■ Other <a href="#">coinsurance</a>                             | 35%   |

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                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$750   |
| <a href="#">Copayments</a>  | \$200   |
| <a href="#">Coinsurance</a> | \$600   |
| What isn't covered          |         |
| Limits or exclusions        | \$0     |
| The total Mia would pay is  | \$1,550 |





FROM



|                            |                                                                                                                                                                                                                                                                                                                          |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Spanish:</b>            | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Buckeye Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1189 (TTY 1-877-941-9236).                                                            |
| <b>Chinese:</b>            | 如果您，或是您正在協助的對象，有關於 Ambetter from Buckeye Health Plan 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 1-877-687-1189 (TTY 1-877-941-9236)。                                                                                                                                                                                      |
| <b>German:</b>             | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Buckeye Health Plan 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 1-877-687-1189 (TTY 1-877-941-9236) an.                                   |
| <b>Arabic:</b>             | إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Buckeye Health Plan، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1189 (TTY 1-877-941-9236).                                                                                                     |
| <b>Pennsylvania Dutch:</b> | Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from Buckeye Health Plan, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kaw! 1-877-687-1189 (TTY 1-877-941-9236).                                      |
| <b>Russian:</b>            | В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Buckeye Health Plan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1189 (TTY 1-877-941-9236). |
| <b>French:</b>             | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Buckeye Health Plan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1189 (TTY 1-877-941-9236).                                      |
| <b>Vietnamese:</b>         | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Buckeye Health Plan, 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 1-877-687-1189 (TTY 1-877-941-9236).                                                    |
| <b>Cushite:</b>            | Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Buckeye Health Plan gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajjin dubadhuu, 1-877-687-1189 irra bilbilli (TTY 1-877-941-9236).                                                            |
| <b>Korean:</b>             | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Buckeye Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1189 (TTY 1-877-941-9236)로 전화하십시오.                                                                                                                              |
| <b>Italian:</b>            | Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Buckeye Health Plan, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-877-687-1189 (TTY 1-877-941-9236).                                                        |
| <b>Japanese:</b>           | Ambetter from Buckeye Health Plan 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、1-877-687-1189 (TTY 1-877-941-9236) までお電話ください。                                                                                                                                                                         |
| <b>Dutch:</b>              | Als u of iemand die u helpt vragen heeft over Ambetter from Buckeye Health Plan, hebt u recht op gratis hulp en informatie in uw taal. Bel 1-877-687-1189 (TTY 1-877-941-9236) om met een tolk te spreken.                                                                                                               |
| <b>Ukrainian:</b>          | В разі виникнення у вас або особи, якій ви допомагаєте, будь-яких запитань щодо програми страхування Ambetter from Buckeye Health Plan ви маєте право отримати безкоштовну допомогу та інформацію на своїй рідній мові. Щоб поговорити з перекладачем, зателефонуйте за номером 1-877-687-1189 (TTY 1-877-941-9236).     |
| <b>Romanian:</b>           | Dacă dvs. sau o persoană pe care o asistați are întrebări despre Ambetter from Buckeye Health Plan, aveți dreptul să obțineți asistență și informații în limba dvs. în mod gratuit. Pentru a vorbi cu un interpret, apelați 1-877-687-1189 (TTY 1-877-941-9236).                                                         |

### Statement of Non-Discrimination

Ambetter from Buckeye Health Plan 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 Buckeye Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Buckeye Health Plan:

- 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 Buckeye Health Plan at 1-877-687-1189 (TTY 1877-941-9236).

If you believe that Ambetter from Buckeye Health Plan 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: Buckeye Health Plan at the Appeals Unit, 4349 Easton Way, Suite 400, Columbus, OH 43219, 1-877-687-1189 (TTY 1-877-941-9236), Fax 1-866-719-5404. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Buckeye Health Plan 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>.