



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://ambetterhealth.com/en/ne/2026-brochures.html> or call 1-833-890-0329 (TTY 711). 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 1-833-890-0329 (TTY 711) to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                          | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0 individual / \$0 family.                                                                                                                                                                                                                                                     | See the Common Medical Events chart below for your cost for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 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> visits, and certain <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> (see additional information below). | 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> : \$8,500 individual / \$17,000 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, penalties for failure to obtain <a href="#">preauthorization</a> for services, 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://ambetterhealth.com/en/ne/fi/ndadoc">https://ambetterhealth.com/en/ne/fi/ndadoc</a> or call 1-833-890-0329 (TTY 711) 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        | \$25 <a href="#">Copay</a> / visit                                                                                                                                                                                                                                              | Not covered                                        | Unlimited Virtual 24/7 Care Visits received from Ambetter's designated telehealth <a href="#">provider</a> covered at No Charge, <a href="#">providers</a> covered in full.                                                                                                   |
|                                                                                                                                                                                                                                                       | <a href="#">Specialist</a> visit                        | \$50 <a href="#">Copay</a> / visit                                                                                                                                                                                                                                              | Not covered                                        | None                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                       | <a href="#">Preventive care/screening</a> /immunization | No charge                                                                                                                                                                                                                                                                       | 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)     | \$25 <a href="#">Copay</a> / visit for laboratory & professional services<br>30% <a href="#">Coinsurance</a> for x-ray & diagnostic imaging<br>30% <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>Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. |
|                                                                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                            | 30% <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                 | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                        |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://ambetterhealth.com/en/ne/2026formulary">https://ambetterhealth.com/en/ne/2026formulary</a> | Generic drugs                                           | Tier 1a - Preferred Generic Retail: \$3 <a href="#">Copay</a> / prescription<br>Tier 1b - Generic Retail: \$20 <a href="#">Copay</a> / prescription                                                                                                                             | 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                                                                                                                                                                                                                      | 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                                                                                        |
|                                                                                                                                                                                                                                                       | Non-preferred brand drugs and Non-preferred generic     | Tier 3 - Retail: \$150 <a href="#">Copay</a> / prescription                                                                                                                                                                                                                     | Not covered                                        |                                                                                                                                                                                                                                                                               |

| 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)                                                                                             |                                                                                                                                                                                                                                                                                                                                |
|                                                                           | drugs.                                           |                                                                                                                                                |                                                                                                                                                | <a href="#">cost-sharing</a> amount.                                                                                                                                                                                                                                                                                           |
|                                                                           | <a href="#">Specialty drugs</a>                  | Tier 4 - 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.                                                                                                                                                                                |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 30% <a href="#">Coinsurance</a>                                                                                                                | Not covered                                                                                                                                    | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
|                                                                           | Physician/surgeon fees                           | 30% <a href="#">Coinsurance</a>                                                                                                                | Not covered                                                                                                                                    | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$1250 <a href="#">Copay</a> / visit (\$625 <a href="#">Copay</a> / visit for facility; \$625 <a href="#">Copay</a> / visit for physician fee) | \$1250 <a href="#">Copay</a> / visit (\$625 <a href="#">Copay</a> / visit for facility; \$625 <a href="#">Copay</a> / visit for physician fee) | None                                                                                                                                                                                                                                                                                                                           |
|                                                                           | <a href="#">Emergency medical transportation</a> | 30% <a href="#">Coinsurance</a>                                                                                                                | 30% <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                                                                                                             | Not covered                                                                                                                                    | None                                                                                                                                                                                                                                                                                                                           |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 30% <a href="#">Coinsurance</a>                                                                                                                | Not covered                                                                                                                                    | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
|                                                                           | Physician/surgeon fees                           | 30% <a href="#">Coinsurance</a>                                                                                                                | Not covered                                                                                                                                    | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office Visit: \$25 <a href="#">Copay</a> / visit;<br>Other Outpatient Services: 30% <a href="#">Coinsurance</a>                                | Not covered                                                                                                                                    | Prior authorization may be required. Covered No Limit. ( <a href="#">Primary Care Provider</a> (PCP) and other practitioner office visits do not require prior authorization.)                                                                                                                                                 |
|                                                                           | Inpatient services                               | 30% <a href="#">Coinsurance</a>                                                                                                                | Not covered                                                                                                                                    | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
| If you are pregnant                                                       | Office visits                                    | \$25 <a href="#">Copay</a> / visit                                                                                                             | Not covered                                                                                                                                    | Prior authorization not required for deliveries within the standard timeframe per federal                                                                                                                                                                                                                                      |

| 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) |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                |                                           |                                                                                              |                                                    | 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 | 30% <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     | 30% <a href="#">Coinsurance</a>                                                              | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 30% <a href="#">Coinsurance</a>                                                              | Not covered                                        | Prior authorization may be required. Limited to 60 visits per year.                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                | <a href="#">Rehabilitation services</a>   | Outpatient: \$35 <a href="#">Copay</a> / visit<br>Inpatient: 30% <a href="#">Coinsurance</a> | Not covered                                        | Outpatient: Prior authorization may be required. Limited to 45 combined visits per year for: physical therapy, occupational therapy, speech therapy, chiropractic physiotherapy and osteopathic physiotherapy (excludes chiropractic/osteopathic manipulative adjustments). Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.<br>Inpatient: Prior authorization may be required. Covered No Limit.       |
|                                                                | <a href="#">Habilitation services</a>     | Outpatient: \$35 <a href="#">Copay</a> / visit<br>Inpatient: 30% <a href="#">Coinsurance</a> | Not covered                                        | Outpatient: Prior authorization may be required. Limited to 45 combined visits per year for: physical therapy, occupational therapy, speech therapy, chiropractic physiotherapy and osteopathic physiotherapy (excludes                                                                                                                                                                                                                              |

| 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) |                                                                                                                                                                                                                     |
|                                               |                                           |                                                      |                                                    | chiropractic/osteopathic manipulative adjustments). Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit. |
|                                               | <a href="#">Skilled nursing care</a>      | 30% <a href="#">Coinsurance</a>                      | Not covered                                        | Prior authorization may be required. Limited to 60 days per year.                                                                                                                                                   |
|                                               | <a href="#">Durable medical equipment</a> | 30% <a href="#">Coinsurance</a>                      | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                              |
|                                               | <a href="#">Hospice services</a>          | 30% <a href="#">Coinsurance</a>                      | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                              |
| <b>If your child needs dental or eye care</b> | 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 member is endangered)</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>        | <ul style="list-style-type: none"> <li>Dental care (Children)</li> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</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>Acupuncture (Limited to 12 visits per year)</li> <li>Chiropractic care (Chiropractic (or osteopathic) manipulative adjustments limited to 20 visits per year)</li> </ul> | <ul style="list-style-type: none"> <li>Hearing aids (Limited to \$3,000 every 48 months)</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 Health at 1-833-890-0329 (TTY 711); The Nebraska Department of Insurance, P.O. Box 95087, Lincoln, Nebraska, 68501-5087; Phone: 1-800-833-7352; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or Office of Personnel Management Multi-State Plan Program at <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/>. 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: The Nebraska Department of Insurance, P.O. Box 95087, Lincoln, Nebraska, 68501-5087; Phone: 1-800-833-7352.

**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? 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 1-833-890-0329 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-890-0329 (TTY 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-890-0329 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-833-890-0329 (TTY 711).

*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> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$50 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%  |
| ■ Other <a href="#">coinsurance</a>                             | 30%  |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$400          |
| <a href="#">Coinsurance</a>       | \$2,600        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,060</b> |

### 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> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$50 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%  |
| ■ Other <a href="#">coinsurance</a>                             | 30%  |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$1,300        |
| <a href="#">Coinsurance</a>       | \$200          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,520</b> |

### Mia's Simple Fracture

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

|                                                                 |      |
|-----------------------------------------------------------------|------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$50 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%  |
| ■ Other <a href="#">coinsurance</a>                             | 30%  |

This EXAMPLE event includes services like:

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$1,000        |
| <a href="#">Coinsurance</a>       | \$400          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,400</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

|                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>English:</b>    | If you, or someone you're helping, have questions about any of the Ambetter Health offerings, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you're helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-833-543-3145 (TTY 711).                                                                                                                  |
| <b>Spanish:</b>    | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de alguno de los ofrecimientos de Ambetter Health y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros al 1-833-543-3145 (TTY 711).                                                                                  |
| <b>Vietnamese:</b> | Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về bất kỳ dịch vụ nào của Ambetter Health và không thành thạo tiếng Anh, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí và kịp thời. Nếu quý vị hoặc người mà quý vị đang giúp đỡ mắc bệnh về thính giác và/hoặc thị giác gây cản trở giao tiếp, quý vị có quyền được nhận các hỗ trợ và dịch vụ phụ trợ miễn phí và kịp thời. Để nhận dịch vụ thông dịch hoặc dịch vụ phụ trợ, vui lòng liên hệ bộ phận Dịch Vụ Thành Viên theo số 1-833-543-3145 (TTY 711).                                                                                                              |
| <b>Arabic:</b>     | إذا كان لديك أو لدى شخص تساعد أسئلة حول أي عرض من عروض Ambetter Health، ولم تكن تجيد التحدث باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت تعاني، أنت أو أي شخص تساعد، من حالة سمعية وأو بصرية تعيق التواصل، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بخدمات الأعضاء على 1-833-543-3145 (TTY 711).                                                                                                                                                                                                           |
| <b>Chinese:</b>    | 如果您或您正在協助的對象對 Ambetter Health 所提供的任何服務有問題，且不精通英語，您有權利免費並及時以您的母語獲得幫助和資訊。如果您或您正在協助的對象有聽力和/或視力上的問題，阻礙了溝通，您有權利免費並及時獲得輔助支援與服務。若要取得翻譯或輔助服務，請聯絡會員服務部，電話是 1-833-543-3145 (TTY 711)。                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>French:</b>     | Si vous même ou une personne que vous aidez avez des questions à propos de l'une des offres d'Ambetter Health et que vous ne maîtrisez pas l'anglais, vous pouvez bénéficier gratuitement et en temps utile d'aide et d'informations dans votre langue. Si vous même ou une personne que vous aidez souffrez d'un trouble auditif ou visuel qui entrave la communication, vous pouvez bénéficier gratuitement et en temps utile d'aides et de services auxiliaires. Pour profiter de services de traduction ou de services auxiliaires, veuillez contacter les Services aux membres au 1-833-543-3145 (TTY 711).                                                    |
| <b>Cushite:</b>    | Isin, ykn namni biraa isin gargaartan, dhiyeessiwwan Ambetter Health ilaalchisee gaaffii qabdu yoo ta'ee fi Afaan Ingiliffaa hin beektanu taanan, yeroodhaan afaan barbaaddaniin kaffaltii tokko malee odeeffannoo barbaaddan argachuudhaaf mirga qabdu. Isin, ykn namni isin gargaartan, rakkoo dhageettii fi/ykn agartii kan haasaa keessan irratti dhiibbaa qabu qabdu taanan, gargaarsa dhageettii argachuu fi tajaajiloota kaffaltii malee argachuudhaaf mirga qabdu. Tajaajiloota hiikkaa afaanii fi dhageettii argachuudhaaf, maaloo Tajaajiloota Maamilaa karaa 1-833-543-3145 (TTY 711) qunnamaa.                                                          |
| <b>Nepali:</b>     | यदि तपाईं स्वयं वा तपाईंले मदद गरिरहनुभएको कोही व्यक्तिसँग Ambetter Health सँग सम्बन्धित प्रश्नहरू छन् र तपाईं दुवै अंग्रेजीमा निपुण हुनुहुन्न भने तपाईंसँग निःशुल्क रूपमा र समयमै आफ्नो भाषामा मदद र जानकारी प्राप्त गर्ने अधिकार छ। यदि तपाईं वा तपाईंले मदद गरिरहनुभएको व्यक्तिसँग सञ्चारमा बाधा पुऱ्याउने श्रवण र/वा दृश्यसम्बन्धी समस्या छ भने तपाईंसँग निःशुल्क रूपमा र समयमै सहायक उपकरण र सेवाहरू प्राप्त गर्ने अधिकार छ। अनुवाद वा सहायक सेवाहरू प्राप्त गर्न कृपया 1-833-543-3145 (TTY 711) मा सदस्य सेवाहरूलाई सम्पर्क गर्नुहोस्।                                                                                                                        |
| <b>Swahili:</b>    | Ikiwa wewe, au mtu unayemsaidia, ana maswali kuhusu yoyote ya matoleo ya Ambetter Health, na huelewi Kiingereza vizuri, una haki ya kupata usaidizi na maelezo kwa lugha yako bila kulipa ada yoyote na kwa wakati ufaa. Ikiwa wewe, au mtu unayemsaidia, ana tatizo la kusikia na/au la kuona ambalo linazuia mawasiliano, una haki ya kupata usaidizi na huduma za ziada bila kulipa ada yoyote na kwa wakati unaofaa. Ili kupata huduma za tafsiri au za ziada, tafadhali wasiliana na Huduma kwa Wanachama 1-833-543-3145 (TTY 711).                                                                                                                            |
| <b>Tagalog:</b>    | Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa alinman sa mga inaalok ng Ambetter Health, at hindi ka mahusay sa Ingles, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o ang iyong tinutulungan, ay may kondisyon sa pandinig at/o paningin na nakakaapekto sa komunikasyon, may karapatan kang makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag ugnayan sa Mga Serbisyo para sa Miyembro sa 1-833-543-3145 (TTY 711). |

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|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Russian:</b> | Если у вас или у лица, которому вы помогаете, возникли вопросы о любых предложениях Ambetter Health, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете, есть нарушения слуха или зрения, которые препятствуют коммуникации, вы имеете право на бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных услуг обратитесь в отдел обслуживания участников по телефону 1-833-543-3145 (TTY 711).                                                                                    |
| <b>Thai:</b>    | หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีคำถามเกี่ยวกับข้อเสนอของ Ambetter Health และไม่สามารถเข้าใจในการใช้ภาษาอังกฤษ คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและข้อมูลในภาษาของคุณโดยไม่เสียค่าใช้จ่ายอย่างเต็มที่ หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีภาวะด้านการฟังและ/หรือการมองเห็นที่เป็นอุปสรรคต่อการสื่อสาร คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและบริการเสริมโดยไม่เสียค่าใช้จ่ายอย่างเต็มที่ หากต้องการบริการด้านการแปลหรือบริการเสริม โปรดติดต่อ บริการสำหรับสมาชิก ที่หมายเลข 1-833-543-3145 (TTY 711)                                                                                                                                                                      |
| <b>Karen:</b>   | နု, မုတမုာ် ပုလုနမၤစၢၤတၢ်ဂၤ, မုာ်အိၣ်ဒီးတၢ်သံကွၢ် ဘၣ်ဃး Ambetter Health အတၢ်ဆိၣ်ထွဲတၢ်မၤလၢ်, ဒီး မုာ်တသုဘၣ် အဲကလံးကျိၣ်ဂုၤန့ၣ်, နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယၢ်လၢကဟံးန့ၣ် တၢ်မၤစၢၤဒီးတၢ်ဂုၤတၢ်ကျိၣ်လၢ နကျိၣ်တၢ်ကတိၤဒၣ်နဲ လၢတလၢ်ဘၣ် ကျိၣ်စ့ဒီးလၢတၢ်ဆၢကတိၤ ဖုၣ်ကိၣ်အပူၤန့ၣ်လီၤ. နု, မုတမုာ် ပုလုနမၤစၢၤတၢ်ဂၤ, အိၣ်ဒီးတၢ်ကိၤတၢ်ခဲတၢ်အိၣ်သးဘၣ်ဃးတၢ်န့ၣ်ဟူတၢ်ဒီး/မုတမုာ် တၢ်ထံၣ် လၢအတြီယာ် တၢ်ဆဲးကျၢဆဲးကျိးအယိ, နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယၢ်လၢနကဒီးန့ၣ် တၢ်မၤစၢၤဆိၣ်ထွဲဒီးတၢ်တိၤစၢၤမၤစၢၤတဖၣ် လၢတလၢ်ဘၣ် ကျိၣ်စ့ဒီးလၢတၢ်ဆၢကတိၤ ဖုၣ်ကိၣ်အပူၤန့ၣ်လီၤ. ဒ်သိးနကဒီးန့ၣ် တၢ်ကတိၤကျိးထံ မုတမုာ် တၢ်မၤစၢၤဆိၣ်ထွဲ အတၢ်ဖဲးတၢ်မၤတဖၣ်အဂီၢ် ဝံသးစူၤဆဲးကျိးဆူ တၢ်မၤစၢၤကရူၢ်ဖိဖဲ 1-833-543-3145 (TTY 711) န့ၣ်တက့ၢ်.          |
| <b>Burmese:</b> | အကယ်၍ သင် သို့မဟုတ် သင်ကူညီနေသူတစ်ဦးသည် Ambetter Health ၏ ကမ်းလှမ်းချက်များနှင့် ပတ်သက်၍ မေးခွန်းများမေးလိုပြီး အင်္ဂလိပ်လို ကျွမ်းကျင်စွာ မပြောနိုင်ပါက၊ သင့်တွင် အကူအညီနှင့် အချက်အလက်များကို သင့်ဘာသာစကားဖြင့် အကြောင်းပြောပေးစရာမလိုဘဲ အချိန်နှင့်တစ်ပြေးညီ ရယူပိုင်ခွင့်ရှိသည်။ အကယ်၍ သင် သို့မဟုတ် သင်ကူညီနေသူတစ်ဦးသည် ဆက်သွယ်ရေးကို အဟန့်အတားဖြစ်စေသော အကြားအာရုံ နှင့်/သို့မဟုတ် အမြင်အာရုံနှင့် သက်ဆိုင်သော အခြေအနေတစ်ခုရှိပါက၊ သင့်တွင် အရန်အကူအညီများနှင့် ဝန်ဆောင်မှုများကို အကြောင်းပြောပေးစရာမလိုဘဲ အချိန်နှင့်တစ်ပြေးညီ ရယူပိုင်ခွင့်ရှိသည်။ ဘာသာပြန် သို့မဟုတ် အရန်ဝန်ဆောင်မှုများကို လက်ခံရယူရန် 1-833-543-3145 (TTY 711) ရှိ အဖွဲ့ဝင် ဝန်ဆောင်မှုများကို ဆက်သွယ်ပါ။ |
| <b>Farsi:</b>   | گر شما یا فردی که دارید به او کمک می کنید، سؤالی درباره هر یک از پیشنهادهای Ambetter Health دارید، و انگلیسی نمی دانید، حق دارید کمک و اطلاعات را به زبان خودتان به رایگان و به موقع دریافت کنید. اگر شما یا فردی که دارید به او کمک می کنید مشکلات شنوایی یا بینایی دارد که برقراری ارتباط را سخت می کند، حق دارید کمک ها و خدمات امدادی را به زبان خودتان به رایگان و به موقع دریافت کنید. برای دریافت کمک ها و خدمات امدادی لطفاً با خدمات اعضا به شماره 1-833-543-3145 تماس بگیرید.                                                                                                                                                                                               |
| <b>Tamil:</b>   | நீங்கள் அல்லது நீங்கள் உதவி செய்யும் ஒருவருக்கு, Ambetter Health சலுகைகள் குறித்து ஏதேனும் கேள்விகள் இருந்தால், மேலும் நீங்கள் ஆங்கிலத்தில் புலமை பெறவில்லை என்றால், உங்கள் மொழியில் உதவி மற்றும் தகவல்களை இலவசமாகவும் சரியான நேரத்திலும் பெற உங்களுக்கு உரிமை உண்டு. நீங்கள் அல்லது நீங்கள் உதவி செய்யும் ஒருவருக்கு, தொடர்புக்கு இடையூறாக இருக்கும் செவிப்புலன் மற்றும்/அல்லது பார்வை கோளாறு இருந்தால், துணை உதவிகள் மற்றும் சேவைகளை இலவசமாகவும் சரியான நேரத்திலும் பெற உங்களுக்கு உரிமை உண்டு. மொழிபெயர்ப்பு அல்லது துணை சேவைகளைப் பெற, தயவுசெய்து உறுப்பினர் சேவைகள் ஐ 1-833-543-3145 (TTY 711) என்ற எண்ணில் தொடர்பு கொள்ளவும்.                                                   |