



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/tn/2026-brochures.html> or call 1-833-709-4735 (Relay 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 1-833-709-4735 (Relay 711) to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                                                                             | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
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| <b>What is the overall <u>deductible</u>?</b>                             | \$0 at Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> at non-IHCP; or \$5,000 individual / \$10,000 family                                                                                                  | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                               |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. <u>Preventive care</u> services, primary care, <u>specialist</u> , and <u>urgent care</u> visits, and certain <u>prescription drugs</u> are covered before you meet your <u>deductible</u> (see additional information below). | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                            |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                                                                                                 | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | For <u>network providers</u> : \$8,650 individual / \$17,300 family. Not applicable for <u>out-of-network providers</u> .                                                                                                           | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> for services, and health care this <u>plan</u> doesn't cover.                                                             | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="https://ambetterhealth.com/en/tn/findadoc">https://ambetterhealth.com/en/tn/findadoc</a> or call 1-833-709-4735 (Relay 711) for a list of <u>network providers</u> .                                              | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |

| Important Questions                                                          | Answers | Why This Matters:                                                                          |
|------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------|
| 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                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                        | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP In-Network Provider<br>(You will pay more)                                                                                                                                                                                                                                                         | Non-IHCP 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       | No charge                                                      | \$30 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                               | 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="#">deductible</a> does not apply. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                     |
|                                                                        | <a href="#">Specialist</a> visit                       | No charge                                                      | \$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                               | Not covered                                                 | None <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                       |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge                                                      | 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)    | No charge                                                      | \$30 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply for laboratory & professional services<br>\$50 <a href="#">Copay</a> / visit for x-ray & diagnostic imaging<br>50% <a href="#">Coinsurance</a> for laboratory & professional services and x-ray & diagnostic imaging at other | Not covered                                                 | Prior authorization may be required. Covered No Limit. Other places of service may include: Hospital, Emergency Room, or Outpatient Facility. Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . |

| Common Medical Event                                                                                                                                                                                                                                                                                      | Services You May Need                                     | What You Will Pay                                           |                                                                                                                                                                                                                                           |                                                          | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                           |                                                           | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more)                                                                                                                                                                                          | Non-IHCP Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                           |                                                           |                                                             | places of service                                                                                                                                                                                                                         |                                                          |                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)                              | No charge                                                   | \$50 <a href="#">Copay</a> / visit                                                                                                                                                                                                        | Not covered                                              | Prior authorization may be required. Covered No Limit. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                    |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="https://ambetterhealth.com/en/tn/2026formulary">prescription drug coverage</a> is available at <a href="https://ambetterhealth.com/en/tn/2026formulary">https://ambetterhealth.com/en/tn/2026formulary</a> | Generic drugs                                             | No charge                                                   | Tier 1a - Preferred Generic Retail: \$3 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply<br>Tier 1b - Generic Retail: \$20 <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 3x retail <a href="#">cost-sharing</a> amount. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . |
|                                                                                                                                                                                                                                                                                                           | Preferred brand drugs                                     | No charge                                                   | 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 3x retail <a href="#">cost-sharing</a> amount. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . |
|                                                                                                                                                                                                                                                                                                           | Non-preferred brand drugs and Non-preferred generic drugs | No charge                                                   | Tier 3 - Retail: 45% <a href="#">Coinsurance</a>                                                                                                                                                                                          | Not covered                                              |                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                           | <a href="#">Specialty drugs</a>                           | No charge                                                   | 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. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a>                                                                             |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                     | Facility fee (e.g., ambulatory surgery center)            | No charge                                                   | 50% <a href="#">Coinsurance</a>                                                                                                                                                                                                           | Not covered                                              | Prior authorization may be required. Covered No Limit. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                           | Physician/surgeon                                         | No charge                                                   | 50% <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                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more)                                                                                                           | Non-IHCP Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                           | fees                                             |                                                             |                                                                                                                                                            |                                                          | <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | No charge                                                   | 50% <a href="#">Coinsurance</a>                                                                                                                            | 50% <a href="#">Coinsurance</a>                          | None <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                           |
|                                                                           | <a href="#">Emergency medical transportation</a> | No charge                                                   | 50% <a href="#">Coinsurance</a>                                                                                                                            | 50% <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="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . |
|                                                                           | <a href="#">Urgent care</a>                      | No charge                                                   | \$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                              | Not covered                                              | None <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                           |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | No charge                                                   | 50% <a href="#">Coinsurance</a>                                                                                                                            | Not covered                                              | Prior authorization may be required. Covered No Limit. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                         |
|                                                                           | Physician/surgeon fees                           | No charge                                                   | 50% <a href="#">Coinsurance</a>                                                                                                                            | Not covered                                              | Prior authorization may be required. Covered No Limit. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                         |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No charge                                                   | Office Visit: \$30 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply;<br>Other Outpatient Services: 50% <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.) <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                 |
|                                                                           | Inpatient services                               | No charge                                                   | 50% <a href="#">Coinsurance</a>                                                                                                                            | Not covered                                              | Prior authorization may be required. Covered No Limit. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                         |
| If you are pregnant                                                       | Office visits                                    | No charge                                                   | \$30 <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                                                                                                                                                                                                                                 |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                           |                                                                                              |                                                          | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more)                                             | Non-IHCP Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                |                                           |                                                             |                                                                                              |                                                          | 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). <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                              |
|                                                                | Childbirth/delivery professional services | No charge                                                   | 50% <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). <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a>                                           |
|                                                                | Childbirth/delivery facility services     | No charge                                                   | 50% <a href="#">Coinsurance</a>                                                              | Not covered                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | No charge                                                   | 50% <a href="#">Coinsurance</a>                                                              | Not covered                                              | Prior authorization may be required. Limited to 60 visits per year. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                     |
|                                                                | <a href="#">Rehabilitation services</a>   | No charge                                                   | Outpatient: \$50 <a href="#">Copay</a> / visit<br>Inpatient: 50% <a href="#">Coinsurance</a> | Not covered                                              | Outpatient: Prior authorization may be required. Limited to 20 visits per year per therapy (occupational therapy, physical therapy and speech therapy); limited to 36 visits per year per therapy for cardiac and pulmonary therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit.<br><a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . |
|                                                                | <a href="#">Habilitation services</a>     | No charge                                                   | Outpatient: \$50 <a href="#">Copay</a> / visit<br>Inpatient: 50% <a href="#">Coinsurance</a> | Not covered                                              | Outpatient: Prior authorization may be required. Limited to 20 visits per year per therapy (occupational therapy, physical therapy and speech therapy); limited to 36 visits per year per therapy for cardiac and pulmonary therapy. Note: Limits do not apply when provided for a                                                                                                                                                                                                           |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                           |                                                      |                                                          | Limitations, Exceptions, & Other Important Information                                                                                                                                                    |
|----------------------------------------|-------------------------------------------|-------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                           | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more)     | Non-IHCP Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                           |
|                                        |                                           |                                                             |                                                      |                                                          | mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit.<br><a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . |
|                                        | <a href="#">Skilled nursing care</a>      | No charge                                                   | 50% <a href="#">Coinsurance</a>                      | Not covered                                              | Prior authorization may be required. Limited 60 days per year. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                       |
|                                        | <a href="#">Durable medical equipment</a> | No charge                                                   | 50% <a href="#">Coinsurance</a>                      | Not covered                                              | Prior authorization may be required. Covered No Limit. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                               |
|                                        | <a href="#">Hospice services</a>          | No charge                                                   | 50% <a href="#">Coinsurance</a>                      | Not covered                                              | Prior authorization may be required. Covered No Limit. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                               |
| If your child needs dental or eye care | Children's eye exam                       | No charge                                                   | No charge; <a href="#">deductible</a> does not apply | Not covered                                              | Limited to 1 exam per year. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                          |
|                                        | Children's glasses                        | No charge                                                   | No charge; <a href="#">deductible</a> does not apply | Not covered                                              | Limited to 1 item per year. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                          |
|                                        | Children's dental check-up                | Not covered                                                 | 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>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> </ul>  | <ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Dental care (Children)</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <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>Chiropractic care (Limited to 20 visits per year)</li> </ul>                                                                                               | <ul style="list-style-type: none"> <li>Hearing aids (Limited to 1 item per ear every 3 years)</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 of Tennessee at 1-833-709-4735 (Relay 711); Tennessee Department of Commerce and Insurance, 500 James Robertson Pkwy., Nashville, TN, 37243-0565, Phone: 1-615-741-2218; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Tennessee Consumer Assistance Program at 1-800-342-4029; 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: Tennessee Department of Commerce and Insurance, 500 James Robertson Pkwy., Nashville, TN, 37243-0565, Phone: 1-615-741-2218. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Tennessee Consumer Assistance Program at 1-800-342-4029.

**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 1-833-709-4735 (Relay 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-709-4735 (Relay 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-709-4735 (Relay 711).

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-709-4735 (Relay 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> | \$5,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$50    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

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>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Peg would pay is</b> | <b>\$0</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> | \$5,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$50    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

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>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Joe would pay is</b> | <b>\$0</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> | \$5,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$50    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

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>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Mia would pay is</b> | <b>\$0</b> |

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.

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



|                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>English:</b>    | If you, or someone you are helping, have questions about Ambetter of Tennessee, 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 are 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 1-833-709-4735 (Relay 711).                     |
| <b>Spanish:</b>    | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter of Tennessee 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 1-833-709-4735 (Relay 711). |
| <b>Arabic:</b>     | إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter of Tennessee، ولم تكن بارعًا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعد تعاني من حالة سمعية و/أو 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 1-833-709-4735 (Relay 711).                                                                                                                |
| <b>Chinese:</b>    | 如果您或您正在協助的對象對 Ambetter of Tennessee 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訊息。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 1-833-709-4735 (Relay 711)。                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Amharic:</b>    | እርስዎ ወይም ሌላ የሚያግዙት ሰው፣ ስለ Ambetter of Tennessee ጥያቄ ካለዎት እና እንግሊዝኛ ብቁ ካልሆኑ፣ ያለምንም ወጪ እና በጊዜው በቋንቋዎ እርዳታ እና መረጃ የማግኘት መብት አልዎት። እርስዎ ወይም ሌላ የሚያግዙት ሰው፣ ግንኙነትን የሚያደናቅፍ የመስማት እና/ወይም የእይታ ችግር ካልዎት፣ ኢንፕር እርዳታዎችን እና አገልግሎቶችን ያለ ምንም ወጪ እና በጊዜው የመቀበል መብት አልዎት። የትርጉም ወይም ረዳት አገልግሎቶችን ለማግኘት እባክዎ በ 1-833-709-4735 (Relay 711) የአባል አገልግሎቶች ን ያናግሩ።                                                                                                                                                                                                             |
| <b>Gujarati:</b>   | જો તમને અથવા તમે જેમની મદદ કરી રહ્યા છો એવી કોઈ વ્યક્તિને Ambetter of Tennessee વિશે ખબરો હોય અને અંગ્રેજીમાં પ્રવીણ ન હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર તમારી ભાષામાં મદદ તથા માહિતી મેળવવાનો અધિકાર છે. જો તમે અથવા તમે જેમની મદદ કરી રહ્યા છો એવી કોઈ વ્યક્તિ શ્રવણશક્તિ અને/અથવા દૃષ્ટિવિષયક અવસ્થાથી પીડિત હોય કે જે સંચારને અવરોધતી હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર સહાયક સહાય તથા સેવાઓ પ્રાપ્ત કરવાનો અધિકાર છે. અનુવાદ અથવા સહાયક સેવાઓ પ્રાપ્ત કરવા માટે, કૃપા કરીને 1-833-709-4735 (Relay 711) પર સભ્યની સેવાઓનો સંપર્ક કરો. |
| <b>Vietnamese:</b> | Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter of Tennessee 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 1-833-709-4735 (Relay 711).                     |
| <b>Laotian:</b>    | ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Ambetter of Tennessee, ແລະ ບໍ່ຊ່ຽວຊານພາສາອັງກິດ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີສະພາບທາງການໄດ້ຍິນ ແລະ/ຫຼື ການເບິ່ງເຫັນທີ່ຂັດຂວາງການສື່ສານ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມເຕີມບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ເພື່ອໃຫ້ໄດ້ຮັບການບໍລິການແປພາສາ ຫຼື ບໍລິການເສີມ, ກະລຸນາຕິດຕໍ່ຫາ ການບໍລິການສະມາຊິກ ໄດ້ທີ່ 1-833-709-4735 (Relay 711).                     |

|                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Swahili:</b>        | Ikiwa wewe, au mtu unayemsaidia, ana maswali kuhusu Ambetter of Tennessee, na huelewi Kiingereza vizuri, una haki ya kupata usaidizi na maelezo kwa lugha yako bila kulipa ada yoyote na kwa wakati ufaao. 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 1-833-709-4735 (Relay 711).                                                                                                                      |
| <b>Ukrainian:</b>      | Якщо у вас або особи, якій ви допомагаєте, виникли запитання щодо плану Ambetter of Tennessee, але ви чи ця особа не володієте англійською мовою, ви маєте право отримати допомогу та інформацію своєю мовою безкоштовно й своєчасно. Якщо у вас або особи, якій ви допомагаєте, є вади слуху або зору, які заважають спілкуванню, ви маєте право отримати допоміжні засоби та послуги безкоштовно й своєчасно. Щоб отримати переклад або додаткові послуги, зв'яжіться зі Службою обслуговування учасників за номером 1-833-709-4735 (Relay 711).                                                                                                |
| <b>Korean:</b>         | 귀하 또는 귀하의 도움을 받는 분이 Ambetter of Tennessee에 대한 질문이 있는 경우 영어에 능숙하지 않으시면 해당 언어로 시의적절하게 무료 지원과 정보를 받을 권리가 있습니다. 귀하 또는 귀하의 도움을 받는 분이 청각 및/또는 시각적으로 의사소통에 장애가 있는 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 통역 또는 보조 서비스를 받으시려면 1-833-709-4735 (Relay 711)번으로 가입자 서비스부에 연락해주시요.                                                                                                                                                                                                                                                                                                                                                                             |
| <b>German:</b>         | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter of Tennessee hat und nicht Englisch spricht, haben Sie das Recht, kostenlos und zeitnah Hilfe und Informationen in Ihrer Sprache zu erhalten. Falls Sie oder jemand, dem Sie helfen, eine Hör- und/oder Sehbeeinträchtigung hat, die die Kommunikation beeinflusst, haben Sie das Recht, kostenlos und zeitnah zusätzliche Hilfe und Dienstleistungen zu erhalten. Um eine Übersetzung oder zusätzliche Dienstleistungen zu erhalten, wenden Sie sich an den Kundendienst unter 1-833-709-4735 (Relay 711).                                                                             |
| <b>Yoruba:</b>         | Bí iwọ, tàbí ẹnikan tí iwọ ń ràn lówó, bá ní ibèèrè nipa Ambetter of Tennessee, tí o kò sì mọ èdè Gẹ̀ẹ̀sì sọ dádádára, o ní ètọ láti rí ìrànlowó àti àlàyé gbà ní èdè rẹ lófẹẹ àti ní àkókò tó yẹ. Bí iwọ, tàbí ẹnikan tí iwọ ń ràn lówó, bá ní ìṣòro ìgbórọ àti/tàbí írírán tó ń dí íbáraẹnisòrọ lówó, o ní ètọ láti gba àwọn ohun ìrànlowó ìgbórọ àti àwọn isẹ ìrànlowó láisanwó àti ní àkókò tó yẹ. Láti gba àwọn isẹ ìtumọ èdè tàbí àwọn isẹ ìrànlowó, jọwọ kàn sí Àwọn isẹ Ọmọ ẹgbẹ ní 1-833-709-4735 (Relay 711).                                                                                                                           |
| <b>French:</b>         | Si vous même ou une personne que vous aidez avez des questions à propos d'Ambetter of Tennessee 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 Services aux membres au 1-833-709-4735 (Relay 711).                                                  |
| <b>Tagalog:</b>        | Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter of Tennessee, 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 pannikin 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 1-833-709-4735 (Relay 711). |
| <b>Haitian Creole:</b> | Si ou menm, oswa yon moun w ap ede, gen kesyon sou Ambetter of Tennessee, epi nou pa mètrize Anglè, nou gen dwa pou jwenn èd ak enfòmasyon nan lang nou gratis epi nan moman ki apwopriye a. Si ou menm, oswa yon moun w ap ede, gen yon pwoblèm pou tande ak/oswa yon pwoblèm pou wè ki pètibe kominikasyon nou, nou gen dwa pou resevwa asistans ak sèvis oksilyè gratis epi nan moman ki apwopriye a. Pou resevwa sèvis tradiksyon oswa sèvis oksilyè yo, tanpri kontakte Sèvis Manm yo nan 1-833-709-4735 (Relay 711).                                                                                                                        |