



# Get to Know Your Plan

Here are all the details about your plan. Please carefully review the information to make sure it's correct.

<b>Plan Name</b>	<b>Subscriber's Coverage Effective Date</b>	
Ambetter Balanced Care 4 (2018)	01/01/18	
<b>Subscriber Name (Policy Owner/Holder)</b>	<b>Subscriber Date of Birth</b>	
John Q Sample	06/18/60	
<b>Policy Number</b>		
99999999		
<b>Your Monthly Premium Amount</b>	<b>Your APTC* (Tax Credit)</b>	<b>Your Monthly Payment After Your APTC*</b>
\$1676.04	\$1631.00	\$45.04

The list below includes the names of all covered members and their member ID numbers. A member ID number is needed in order to create an online member account.

## Covered Individuals

Jane Q Sample U9999999902  
Mary Q Sample U9999999903

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Ambetter DaliCare 4 (ZU10) (Silver Level)						NOTES
Medical Annual Deductible	Individual: \$600; Family: \$1,200	0% Coinsurance				
Prescription Drug Annual Deductible	Individual: Integrated with medical deductible	Family: Integrated with medical deductible				
Prescription Drug Coinsurance	Integrated with medical coinsurance					
Maximum Annual Out-of-pocket	Individual: \$600; Family: \$1,200					
<b>Emergency Services</b>	<b>Your Cost</b> (In-Network Providers only)			<b>Out-of-Network</b>	<b>Subject to Deductible</b>	
Emergency Room Services	No charge after deductible		No charge after deductible		Yes	
Emergency Transportation/Ambulance (Air or Ground)	No charge after deductible		No charge after deductible		Yes	
Urgent Care	\$10 Copay		Not covered		No	
<b>Provider Services</b>						
Annual Well Visit/Screening/Immunization/Well Baby	No charge		Not covered		No	
Primary Care Visit to treat an injury or illness and Maternity	No charge		Not covered		No	
Specialist Visit (e.g. Cardiology, Podiatry, Chiropractic Care)	\$5 Copay		Not covered		No	
Imaging (CT/PET Scans, MRIs)	No charge after deductible		Not covered		Yes	
X-rays & Diagnostic Imaging	No charge after deductible		Not covered		Yes	
<b>Inpatient &amp; Outpatient Services</b>						
Inpatient Facility Fee (Includes Mental Health, Substance Use and Maternity)	No charge after deductible		Not covered		Yes	
Inpatient Physician & Surgical Services	No charge after deductible		Not covered		Yes	
Outpatient Facility Fee (e.g. Ambulatory Surgery Center)	No charge after deductible		Not covered		Yes	
Outpatient Surgery Physician/Surgical Services	No charge after deductible		Not covered		Yes	
Laboratory Outpatient & Professional Services	No charge after deductible		Not covered		Yes	
<b>Other Medical Services</b>						
Mental/Behavioral Health & Substance Use Disorder Outpatient Services	No charge for office visits; No charge after deductible for all other outpatient services		Not covered		No	
Rehabilitation Outpatient Services (Includes Speech, Occupational and Physical Therapy)	No charge after deductible		Not covered		Yes	
<b>Pediatric Vision</b>						
Routine Eye Exam (1 visit per year)	100% Covered		Not covered		No	
Eyeglasses (frames, 1 item per year)	100% Covered		Not covered		No	
Lenses (per pair)	100% Covered		Not covered		No	
<b>Prescription Drugs</b>						
Generics*	No charge		Not covered		No	
Preferred Brand Drugs	\$25 Copay		Not covered		No	
Non-preferred Brand Drugs	No charge after deductible		Not covered		Yes	
Specialty Drugs	No charge after deductible		Not covered		Yes	
*If the cost of the generic drug is less than the copay, you pay the lesser amount.						
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# Ambetter Data Sheet (2010)

**(Silver Level)**

Medical Annual Deductible

Medical Coinsurance

Prescription Drug Annual Deductible

**Individual:** Integrated with medical deductible;  
**Family:** Integrated with medical deductible  
integrated with medical coinsurance

Individual: \$600; Family: \$1,200

Maximum Annual Out-of-pocket

**Emergency Services**

	<b>Your Cost</b> (In-Network Providers only)	<b>Out-of-Network</b>	<b>Subject to Deductible</b>
Emergency Room Services	No Charge after deductible	No charge after deductible	Yes
Emergency Transportation/Ambulance (Air or Ground)	No charge after deductible	No charge after deductible	Yes
Urgent Care	\$10 Copay	Not covered	No

**Provider Services**

Annual Well Visit/Screening/Immunization/Well Baby	No charge	Not covered	No
Primary Care Visit to treat an injury or illness and Maternity	No charge	Not covered	No
Specialist Visit (e.g. Cardiology, Podiatry, Chiropractic Care)	\$5 Copay	Not covered	No
Imaging (CT/PET Scans, MRIs)	No charge after deductible	Not covered	Yes
X-rays & Diagnostic Imaging	No charge after deductible	Not covered	Yes

**Inpatient & Outpatient Services**

Inpatient Facility Fee (Includes Mental Health, Substance Use and Maternity)	No charge after deductible	Not covered	Yes
Inpatient Hospital Physician & Surgical Services	No charge after deductible	Not covered	Yes
Outpatient Facility Fee (e.g. Ambulatory Surgery Center)	No charge after deductible	Not covered	Yes
Outpatient Surgery Physician/Surgical Services	No charge after deductible	Not covered	Yes
Laboratory Outpatient & Professional Services	No charge after deductible	Not covered	Yes

**Other Medical Services**

Mental/Behavioral Health & Substance Use Disorder Outpatient Services	No charge for office visits; No charge after deductible for all other outpatient services	Not covered	No
Rehabilitation Outpatient Services (Includes Speech, Occupational and Physical Therapy)	No charge after deductible	Not covered	Yes

**Pediatric Vision**

Routine Eye Exam (1 visit per year)	100% Covered	Not covered	No
Eyeglasses (frames, 1 item per year)	100% Covered	Not covered	No
Lenses (per pair)	100% Covered	Not covered	No

**Prescription Drugs**

Generics*	No charge	Not covered	No
Preferred Brand Drugs	\$25 Copay	Not covered	No
Non-preferred Brand Drugs	No charge after deductible	Not covered	Yes
Specialty Drugs	No charge after deductible	Not covered	Yes

\*If the cost of the generic drug is less than the copay, you pay the lesser amount.  
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**NOTES**





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# Ambetter Data Sheet (2010)

## (Silver Level)

**Individual:** \$600; **Family:** \$1,200

0% Coinsurance

**Prescription Drug Annual Deductible**

**Family:** Integrated with medical deductible

Integrated with medical coinsurance

**Maximum Annual Out-of-pocket**

**Individual:** \$600; **Family:** \$1,200

### Emergency Services

	<b>Your Cost</b> (In-Network Providers only)	<b>Out-of-Network</b>	<b>Subject to Deductible</b>
Emergency Room Services	No Charge after deductible	No charge after deductible	Yes
Emergency Transportation/Ambulance (Air or Ground)	No charge after deductible	No charge after deductible	Yes
Urgent Care	\$10 Copay	Not covered	No

### Provider Services

Annual Well Visit/Screening/Immunization/Well Baby	No charge	Not covered	No
Primary Care Visit to treat an injury or illness and Maternity	No charge	Not covered	No
Specialist Visit (e.g. Cardiology, Podiatry, Chiropractic Care)	\$5 Copay	Not covered	No
Imaging (CT/PET Scans, MRIs)	No charge after deductible	Not covered	Yes
X-rays & Diagnostic Imaging	No charge after deductible	Not covered	Yes

### Inpatient & Outpatient Services

Inpatient Facility Fee (Includes Mental Health, Substance Use and Maternity)	No charge after deductible	Not covered	Yes
Inpatient Hospital Physician & Surgical Services	No charge after deductible	Not covered	Yes
Outpatient Facility Fee (e.g. Ambulatory Surgery Center)	No charge after deductible	Not covered	Yes
Outpatient Surgery Physician/Surgical Services	No charge after deductible	Not covered	Yes
Laboratory Outpatient & Professional Services	No charge after deductible	Not covered	Yes

### Other Medical Services

Mental/Behavioral Health & Substance Use Disorder Outpatient Services	No charge for office visits. No charge after deductible for all other outpatient services	Not covered	No
Rehabilitation Outpatient Services (includes Speech, Occupational and Physical Therapy)	No charge after deductible	Not covered	Yes

### Pediatric Vision

Routine Eye Exam (1 visit per year)	100% Covered	Not covered	No
Eyeglasses (frames, 1 item per year)	100% Covered	Not covered	No
Lenses (per pair)	100% Covered	Not covered	No

### Prescription Drugs

Generics*	No charge	Not covered	No
Preferred Brand Drugs	\$25 Copay	Not covered	No
Non-preferred Brand Drugs	No charge after deductible	Not covered	Yes
Specialty Drugs	No charge after deductible	Not covered	Yes

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**Ambetter Balanced Care 4 (2018)**  
(Silver Level)

**ambetter. FROM peach state health plan.**

**Covered benefits are for in-network providers only.**  
To find our most up to date list of in-network providers, please visit our website at Ambetter.pshgeorgia.com and select "Find a Provider" in the main menu. Providers listed in the Ambetter from Peach State Health Plan online directory are in-network.

	<b>Your Cost</b> (In-Network Providers only)	<b>Out-of-Network</b>	<b>Subject to Deductible</b>
Medical Annual Deductible	No charge after deductible	No charge after deductible	Yes
Medical Coinsurance	No charge	No charge	No
Prescription Drug Annual Deductible	No charge	No charge	No
Prescription Drug Coinsurance	\$5 Copay	No charge	No
Maximum Annual Out-of-pocket	\$1,200	No charge after deductible	No
<b>Emergency Services</b>			
Emergency Room Services	No charge after deductible	No charge after deductible	Yes
Emergency Transportation/Ambulance (Air or Ground)	No charge after deductible	No charge after deductible	Yes
Urgent Care	\$10 Copay	Not covered	No
<b>Provider Services</b>			
Annual Well Visit/Screening/Immunization/Well Baby	No charge	No charge	No
Primary Care Visit to treat an injury or illness and Maternity	No charge	No charge	No
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Imaging (CT/PE Scans, MRIs)	No charge after deductible	No charge	Yes
X-rays & Diagnostic Imaging	No charge after deductible	No charge	Yes
<b>Inpatient &amp; Outpatient Services</b>			
Inpatient Facility Fee (Includes Mental Health, Substance Use and Maternity)	No charge after deductible	No charge	Yes
Inpatient Hospital Physician & Surgical Services	No Charge after deductible	No charge	Yes
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Outpatient Surgery Physician/Surgical Services	No charge after deductible	No charge	Yes
Laboratory Outpatient & Professional Services	No charge after deductible	No charge	Yes
<b>Other Medical Services</b>			
Mental/Behavioral Health & Substance Use Disorder Outpatient Services	No charge for office visits; No charge after deductible for all other outpatient services	No charge	No
Rehabilitation Outpatient Services (includes Speech, Occupational and Physical Therapy)	No charge after deductible	No charge	Yes
<b>Pediatric Vision</b>			
Routine Eye Exam (1 visit per year)	100% Covered	Not covered	No
Eyeglasses (frames, 1 item per year)	100% Covered	Not covered	No
Lenses (per pair)	100% Covered	Not covered	No
<b>Prescription Drugs</b>			
Generics*	No charge	Not covered	No
Preferred Brand Drugs	\$25 Copay	Not covered	No
Non-preferred Brand Drugs	No charge after deductible	Not covered	Yes
Specialty Drugs	No charge after deductible	Not covered	Yes

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## NOTES



**Staying healthy  
matters to you  
and to us.**



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Prescription Drug Annual Deductible	No charge	No charge	No
Prescription Drug Coinsurance	\$5 Copay	No charge	No
Maximum Annual Out-of-pocket	\$1,200	No charge after deductible	No
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Preferred Brand Drugs	\$25 Copay	Not covered	No
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Specialty Drugs	No charge after deductible	Not covered	Yes

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## NOTES

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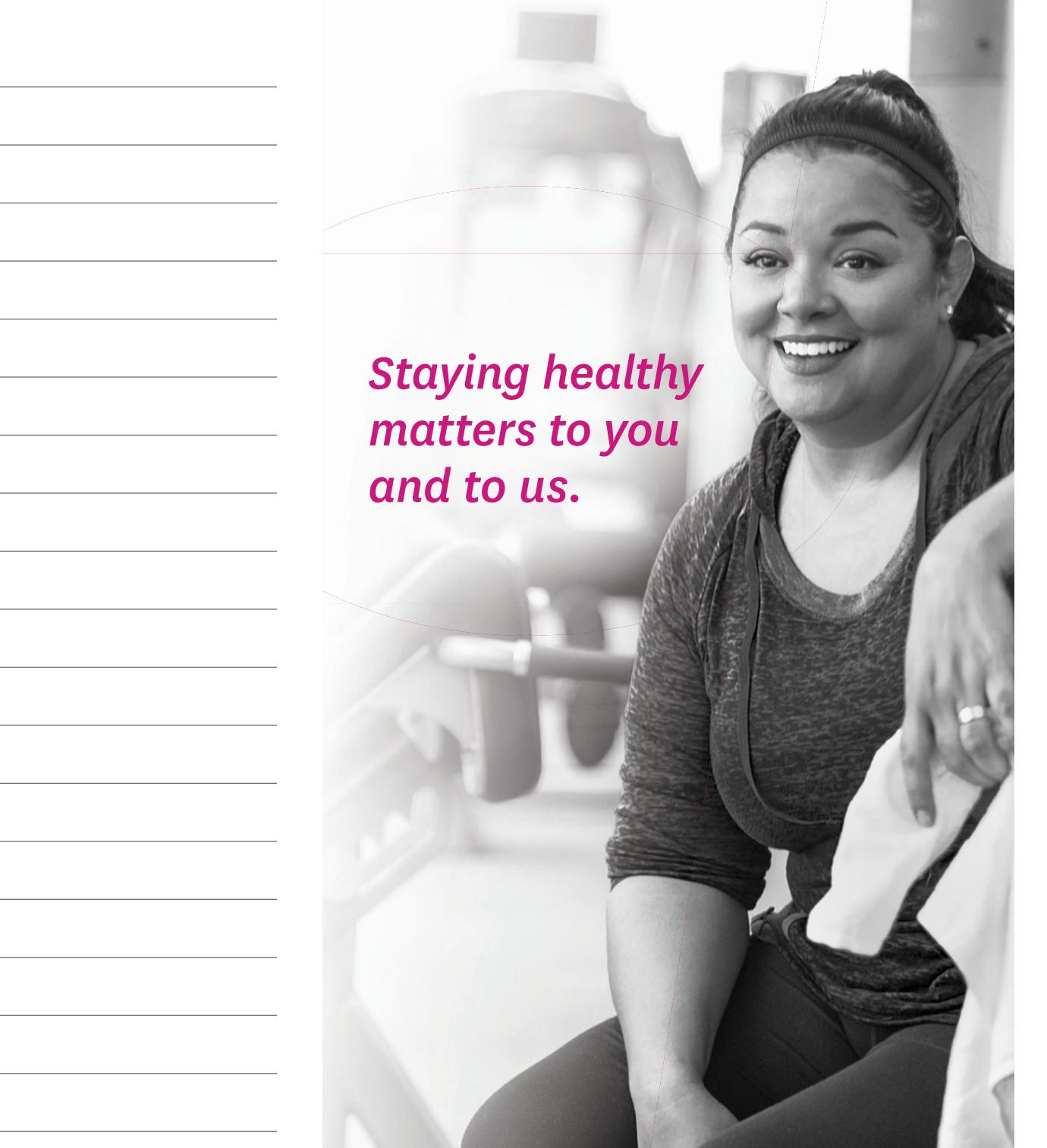
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