Get to Know Your Plan

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

Plan Name

Ambetter Balanced Care 1 (2019)

Subscriber's Coverage Effective Date

01/01/19

Subscriber Name (Policy Owner/Holder)

Vraj Patel

Subscriber Date of Birth

12/07/95

Policy Number

92765130

Member ID

U9276513001

Your Monthly Premium Amount	Your APTC* (Tax Credit)	Your Monthly Payment After Your APTC*
$363.03	$353.00	$10.03

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

*An APTC (Advance Premium Tax Credit) provides financial help for qualifying members. It is your tax credit to help lower your monthly payment. Your monthly payment is a result of your monthly premium amount subtracted by your APTC amount.

For printed copies of your member materials or assistance in finding a provider, call Member Services at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989). You can also access electronic copies of your Member Handbook, Evidence of Coverage, Schedule of Benefits and more by logging in to your online member account at Member.AmbetterHealth.com.

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Ambetter Balanced Care 1 (2019)

(Silver Level)

Medical Annual Deductible	**Individual:** $0; **Family:** $0
Medical Coinsurance	20% 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:** $1,075; **Family:** $2,150

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.SuperiorHealthPlan.com and select "Find a Provider" in the main menu. Providers listed in the Ambetter from Superior HealthPlan online directory are in-network.

Emergency Services	**Your Cost** (In-Network Providers Only)	**Out-of-Network**	**Subject to Deductible**
Emergency Room Services	20% Coinsurance	20% Coinsurance	No
Emergency Transportation/Ambulance (Air or Ground)	20% Coinsurance	20% Coinsurance	No
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)	$10 Copay	Not covered	No
Imaging (CT/PET Scans, MRIs)	20% Coinsurance	Not covered	No
X-rays & Diagnostic Imaging	20% Coinsurance	Not covered	No
Inpatient & Outpatient Services			
Inpatient Facility Fee (Includes Mental Health, Substance Use and Maternity)	20% Coinsurance	Not covered	No
Inpatient Hospital Physician & Surgical Services	20% Coinsurance	Not covered	No
Outpatient Facility Fee (e.g. Ambulatory Surgery Center)	20% Coinsurance	Not covered	No
Outpatient Surgery Physician/Surgical Services	20% Coinsurance	Not covered	No
Laboratory Outpatient & Professional Services	20% Coinsurance	Not covered	No
Other Medical Services			
Mental/Behavioral Health & Substance Use Disorder Outpatient Services	No charge/Office Visit; 20% Coinsurance for all other services	Not covered	No
Rehabilitation Outpatient Services (includes Speech, Occupational and Physical Therapy)	20% Coinsurance	Not covered	No
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	20% Coinsurance	Not covered	No
Specialty Drugs	20% Coinsurance	Not covered	No

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

Information shown represents a 94% AV Cost Share Plan. Our plans do not cover all health care expenses. Covered benefits will vary by state and are for in-network providers only. For comprehensive benefit detail, members should review their Evidence of Coverage and Schedule of Benefits prior to receiving services. Exclusions and limitations may apply.

For help understanding the terms used above, see the Health Insurance Terms page on Ambetter.SuperiorHealthPlan.com.

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