ambetter.™

Balanced Care 87 Plans

YOUR HEALTH. OUR PRIORITY.

FROM superior healthplan™

For years, Superior HealthPlan has delivered quality healthcare solutions to help Texas residents live better. And with Ambetter, our Health Insurance Marketplace insurance plan, we offer a variety of affordable options that make it easier to stay healthy—and to stay covered.

At Superior, we believe that nothing is more important than your health. We also believe that you deserve to get the most out of your Marketplace health insurance plan.

That's why we make sure our Ambetter plans fit your health needs and your budget. But our focus doesn't stop there. In fact, our commitment to your well-being extends far beyond the doctor's office and into your everyday life. Superior is active in your local community—and we're dedicated to helping you live well.

Our Ambetter plans also offer a wide variety of valuable programs, educational tools and support. With Ambetter from Superior HealthPlan it's easy to stay in charge of your health. And to lead a healthy, fulfilling life.

Comprehensive Medical Care
Complete medical care that covers all of your Essential Health Benefits.

My Health Pays™ Program
Earn reward dollars just by staying proactive about your health.

Optional Adult Dental Coverage
Coverage for services such as teeth cleanings, screenings and exams.

Vision Coverage
Pediatric coverage for services such as eye exams and prescription eyewear. Optional adult vision coverage also available.

24/7 Nurse Advice Line
Call and talk to a registered nurse 24 hours a day, 7 days a week to ask questions or get medical advice.

Integrated Care Management
Get well and stay well with preventive care and whole health services.

Gym Reimbursement Program
Ambetter's gym membership benefits program makes it easier to stay in shape and stay healthy.

Prescription Coverage
Get coverage for your medical prescriptions.

Health Insurance Marketplace

Ambetter from Superior HealthPlan is a Qualified Health Plan issuer in the Texas Health Insurance Marketplace and does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

Enroll TODAY!

Call us today at 1-877-687-1196 (Relay Texas/ TTY: 1-800-735-2989) or visit us at Ambetter.SuperiorHealthPlan.com.

Balanced Care 87 Plans (silver level)

	Balanced Care 1	Balanced Care 2	Balanced Care 3	Balanced Care 4	Balanced Care 5
Medical Annual Deductible	**Individual:** $150; **Family:** $300	**Individual:** $1,500; **Family:** $3,000	**Individual:** $500; **Family:** $1,000	**Individual:** $500; **Family:** $1,000	**Individual:** $500; **Family:** $1,000
Medical Coinsurance	70/30% coinsurance after annual deductible	100/0% coinsurance after annual deductible	90/10% coinsurance after annual deductible	90/10% coinsurance after annual deductible	100/0% coinsurance after annual deductible
Prescription Drug Annual Deductible	**Individual:** $150; **Family:** $300	Rx Deductible integrated with Medical Deductible	**Individual:** $200; **Family:** $400	Rx Deductible integrated with Medical Deductible	**Individual:** $100; **Family:** $200
Prescription Drug Coinsurance	50/50% coinsurance after annual deductible	100/0% coinsurance after annual deductible	70/30% coinsurance after annual deductible	90/10% coinsurance after annual deductible	Not Applicable
Maximum Annual Out-of-Pocket	**Individual:** $2,250; **Family:** $4,500	**Individual:** $1,500; **Family:** $3,000	**Individual:** $2,250; **Family:** $4,500	**Individual:** $2,250; **Family:** $4,500	**Individual:** $2,250; **Family:** $4,500
Emergency Services	**Your Cost (In-Network Providers only)**	**Your Cost (In-Network Providers only)**	**Your Cost (In-Network Providers only)**	**Your Cost (In-Network Providers only)**	**Your Cost (In-Network Providers only)**
Emergency Room Services	$250 copay after annual deductible*	0% coinsurance after annual deductible*	$150 copay after annual deductible*	$100 copay after annual deductible*	$100 copay after annual deductible*
Emergency Transportation/Ambulance (Air or Ground)	30% coinsurance after annual deductible*	0% coinsurance after annual deductible*	10% coinsurance after annual deductible*	10% coinsurance after annual deductible*	0% coinsurance after annual deductible*
Urgent Care	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay
Provider Services					
Annual Well Visit/Screening/Immunization/Well Baby	No Charge	No Charge	No Charge	No Charge	No Charge
Primary Care Visit to treat an injury or illness and Maternity	$1 copay	$1 copay	$10 copay	$5 copay	$10 copay
Specialist Visit (e.g. Cardiology, Podiatry, Chiropractic Care)	$5 copay	$5 copay	$30 copay	$10 copay	$20 copay
Imaging (CT/PET Scans, MRIs)	30% coinsurance after annual deductible	0% coinsurance after annual deductible	10% coinsurance after annual deductible	10% coinsurance after annual deductible	$50 copay after annual deductible
X-rays & Diagnostic Imaging	30% coinsurance after annual deductible	0% coinsurance after annual deductible	10% coinsurance after annual deductible	10% coinsurance after annual deductible	$10 copay after annual deductible
Inpatient & Outpatient Services					
Inpatient Hospital Services (Includes Mental Health & Substance Abuse and Maternity)	30% coinsurance after annual deductible	0% coinsurance after annual deductible	10% coinsurance after annual deductible	10% coinsurance after annual deductible	0% coinsurance after annual deductible
Inpatient Hospital Fee	30% coinsurance after annual deductible	0% coinsurance after annual deductible	10% coinsurance after annual deductible	10% coinsurance after annual deductible	$250 copay per stay after annual deductible
Outpatient Facility Fee (e.g. Ambulatory Surgery Center)	30% coinsurance after annual deductible	0% coinsurance after annual deductible	10% coinsurance after annual deductible	10% coinsurance after annual deductible	$50 copay after annual deductible
Outpatient Surgery Physician/Surgical Services	30% coinsurance after annual deductible	0% coinsurance after annual deductible	10% coinsurance after annual deductible	10% coinsurance after annual deductible	0% coinsurance after annual deductible
Laboratory Outpatient & Professional Services	30% coinsurance after annual deductible	0% coinsurance after annual deductible	10% coinsurance after annual deductible	10% coinsurance after annual deductible	$10 copay after annual deductible
Other Medical Services					
Mental/Behavioral Health & Substance Abuse Disorder Outpatient Services	$1 copay	$1 copay	10% coinsurance after annual deductible	10% coinsurance after annual deductible	$50 copay after annual deductible
Rehabilitative Speech Therapy/Rehabilitative Occupational & Rehabilitative Physical Therapy	30% coinsurance after annual deductible	0% coinsurance after annual deductible	10% coinsurance after annual deductible	10% coinsurance after annual deductible	$10 copay after annual deductible
Skilled Nursing Facility	30% coinsurance after annual deductible	0% coinsurance after annual deductible	10% coinsurance after annual deductible	10% coinsurance after annual deductible	$100 copay per stay after annual deductible
Pediatric Vision					
Routine Eye Exam (1 visit per year)	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay
Eyeglasses (frames, 1 item per year)	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay
Lenses (per pair)	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay
Prescription Drugs					
Generics	$1 copay**	$1 copay**	$5 copay**	$5 copay**	$10 copay**
Preferred Brand Drugs	$30 copay after annual prescription drug deductible	$25 copay	$25 copay after annual prescription drug deductible	$25 copay after annual deductible	$20 copay after annual prescription drug deductible
Non-preferred Brand Drugs	50% coinsurance after annual prescription drug deductible	0% coinsurance after annual deductible	$75 copay after annual prescription drug deductible	$75 copay after annual deductible	$40 copay after annual prescription drug deductible
Specialty Drugs	50% coinsurance after annual prescription drug deductible	0% coinsurance after annual deductible	30% coinsurance after annual prescription drug deductible, $350 maximum per prescription	10% coinsurance after annual deductible	$250 copay after annual prescription drug deductible
Optional Services					
Optional Adult Vision or Adult Vision/Dental coverage also available. See details on back.			Optional Adult Vision or Adult Vision/Dental coverage also available. See details on back.		

*Eligible Out-of-network expenses are covered at the In-network level.
**If the cost of the generic drug is less than the copay, you pay the lesser amount.
Information shown represents a 87% Actuarial Value. This is only a summary of the major benefits provided by our plans. This is not a contract. Benefits may vary by state.
For help understanding the terms used above, see the *Words to Know* page on Ambetter.SuperiorHealthPlan.com.

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Adult Vision Benefits *(Optional)*

(Ages 19 years of age and older)

	Your Cost (In-network Providers only)	Out-of-network
Routine Eye Exam (1 visit per year)	100% covered after $20 copay	Not Covered
Eyeglass Frames or Contacts (in lieu of glasses)	Covered up to $130 after $20 copay	Not Covered
Lenses for Eyeglasses (per pair)	100% covered after $20 copay	Not Covered

Adult Dental Benefits* *(Optional)*

(Ages 19 years of age and older, does not include Pediatric Dental coverage)

Annual Maximun Dental Benefit**	$1,000 per covered person per calendar year

Basic Dental (Class 1)	Your Cost (In-network Providers only)	Out-of-network
Routine Oral Exam (1 per 6 months)	No Charge, subject to Annual Maximum	Not Covered
Routine Cleaning (1 per 6 months)	No Charge, subject to Annual Maximum	Not Covered
X-rays (1 per 12 months)	No Charge, subject to Annual Maximum	Not Covered

Comprehensive Dental (Class 2)***		
Basic Services: Fillings (1 per 2 years)	50% coinsurance, subject to Annual Maximum	Not Covered
Periodontics: Scaling & Root Planning (1 per 24 months)	50% coinsurance, subject to Annual Maximum	Not Covered
Oral Surgery: Simple Extractions	50% coinsurance, subject to Annual Maximum	Not Covered
Prosthodontics	50% coinsurance, subject to Annual Maximum	Not Covered

*If you require coverage for Pediatric Dental please shop on the Health Insurance Marketplace for a stand alone dental plan.
**Dental Annual Maximum Benefit does not apply toward any other maximums.
***Please Note: Comprehensive Dental Benefits (Class 2) are subject to a six month waiting period until services can be rendered.

IMPORTANT NOTE: The information shown in this brochure and in any accompanying literature is not intended to provide full details of Ambetter plans and may change at the discretion of Superior HealthPlan. Complete terms of coverage are outlined in the Schedule of Benefits and set forth in the applicable Member Contract. In applying for coverage, the primary insured agrees to be bound by the Member Contract. The benefits described in this brochure and any accompanying literature are the standard benefits offered by Ambetter from Superior HealthPlan. Policy provisions vary in some states. This is a solicitation for insurance.

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