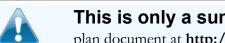
Ambetter Platinum 2 of Massachusetts

Summary of Benefits and Coverage: What this Plan Covers & What it Costs



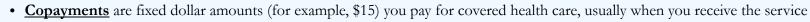
ambetter.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://ambetter.celticarehealthplan.com/ or by calling 877-687-1186, TTY/TDD 877-941-9234

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$500 individual / \$1,000 family. Does not apply to preventive care and prescription drugs.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy plan or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-</u> <u>pocket-limit</u> on my expenses?	Yes, for in-network providers \$1,500 individual/\$3,000 family. No, for out-of-network providers.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and out-of-network services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. See http://ambetter. celticarehealthplan.com/ findadoc or call 1-877-687-1186 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	Yes	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 877-687-1186, TTY/TDD 877-941-9234 or visit us at http://ambetter.celticarehealthplan.com/. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 877-687-1186, TTY/TDD 877-941-9234 to request a copy. 31234MA0370002-01

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- <u>Coinsurance</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need		Your Cost If You Use an Out-of- network Provider	Limitations & Exceptions
If many article a the alter	Primary care visit to treat an injury or illness	\$20 Copay/visit	Not covered	None
If you visit a health care <u>provider's</u> office	Specialist visit	\$35 Copay/visit	Not covered	None
or clinic	Other practitioner office visit	\$20 Copay/visit	Not covered	None
of child	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	\$20 Copay after deductible	Not covered	Prior approval required
n you nave a test	Imaging (CT/PET scans, MRIs)	\$100 Copay after deductible	Not covered	Prior approval required

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period:

Coverage for: Individual/Family | Plan Type:HMO

Common Medical Event	Services You May Need	You Use an In-	Your Cost If You Use an Out-of- network Provider	Limitations & Exceptions
	Generic drugs	Retail: \$15 Copay/30 day supply. Mail Order: \$30 Copay/90 day supply	Not covered	None
If you need drugs to treat your illness or condition More information	Preferred brand drugs	Retail: \$25 Copay/30 day supply. Mail Order: \$50 Copay/90 day supply	Not covered	
More information about <u>prescription</u> <u>drug coverage</u> is available at http:// ambetter.celticarehealthp	Non-preferred brand drugs	Retail: \$45 Copay/30 day supply. Mail Order: \$135 Copay/90 day supply	Not covered	None
	Specialty drugs	Retail: \$45 Copay/30 day supply. Mail Order: \$135 Copay/90 day supply	Not covered	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	\$0 Copay after deductible	Not covered	Prior approval required
surgery	Physician/surgeon fees	\$0 Copay after deductible	Not covered	Prior approval required
If you need immediate	Emergency room services	\$100 Copay after deductible /visit	\$100 Copay after deductible /visit	None
medical attention	Emergency medical transportation	\$0 Copay after deductible	\$0 Copay after deductible	None
	Urgent care	\$100 Copay/visit	Not covered	None

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Coverage Period:

Coverage for: Individual/Family | Plan Type:HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In- network Provider		Limitations & Exceptions
If you have a hospital	Facility fee (e.g., hospital room)	\$0 Copay after deductible	Not covered	Prior approval required
stay	Physician/surgeon fee	\$0 Copay after deductible	Not covered	Prior approval required
	Mental/Behavioral health outpatient services	\$20 Copay/visit	Not covered	Prior approval required
If you have mental health, behavioral	Mental/Behavioral health inpatient services	No Charge after deductible	Not covered	Prior approval required
health, or substance	Substance use disorder outpatient services	\$20 Copay/visit	Not covered	Prior approval required
abuse needs	Substance use disorder inpatient services	No Charge after deductible	Not covered	Prior approval required.
	Prenatal and postnatal care	\$20 Copay/visit	Not covered	None
If you are pregnant	Delivery and all inpatient services	No Charge after deductible	Not covered	Prior approval required

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Coverage Period:

Coverage for: Individual/Family | Plan Type:HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In- network Provider	Your Cost If You Use an Out-of- network Provider	Limitations & Exceptions
	Home health care	No Charge after deductible	Not covered	Prior approval required
	Rehabilitation services	\$20 Copay after deductible	Not covered	60 Visit(s) per Year. No limit applies to autism, home health care, and speech/hearing disorders.
If you need help recovering or have other special health needs	Habilitation services	\$20 Copay after deductible	Not covered	Prior approval required after limits have been met. 60 Visit(s) per Year. No limit applies to autism, home health care, and speech/hearing disorders.
	Skilled nursing care	No Charge after deductible	Not covered	100 Days per Year
	Durable medical equipment	\$20 Copay after deductible	Not covered	Prior approval required
	Hospice service	No Charge after deductible	Not covered	Prior approval required
If your child needs	Eye exam	\$20 Copay/visit	Not covered	1 Exam(s) per 2 Years
dental or eye care	Glasses	\$20 Copay/pair	Not covered	1 Item(s) per 2 Years
dental of cyc care	Dental check-up	Not covered	Not covered	None

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Excluded Services & Other Covered Services

Services Your Plan Does Not Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)			
• Acupuncture	Cosmetic surgery	Dental care (Adult)	
• Dental care (child)	• Long-term care	• Non-emergency care when traveling outside	
Private-duty nursing	• Routine eye care (Adult)	the U.S.	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

• Abortion services for which Federal funds are	Bariatric surgery	Chiropractic care	
prohibited	Infertility treatment	Routine foot care	
• Hearing aids			
Weight loss programs			

Your Rights to Continue Coverage

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 877-687-1186, TTY/TDD 877-941-9234. You may also contact your state insurance department at Division of Insurance 1000 Washington St, Suite 810 Boston, MA 02118-6200 (877)-563-4467 (Toll Free).

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Division of Insurance 1000 Washington St, Suite 810 Boston, MA 02118-6200 (877)-563-4467 (Toll Free).

Additionally, a consumer assistance program can help you file your appeal. Contact (617) 521-7794.

Questions: Call 877-687-1186, TTY/TDD 877-941-9234 or visit us at http://ambetter.celticarehealthplan.com/. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 877-687-1186, TTY/TDD 877-941-9234 to request a copy. 31234MA0370002-01

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy <u>does</u> <u>provide</u> minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage <u>does meet</u> the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 877-687-1186, TTY/TDD 877-941-9234

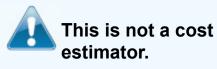
- To see examples of how this plan might cover costs for a sample medical situation, see the next page. -

from CeltiCare Health Plan Ambetter Platinum 2

Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,690
- Patient pays \$850

Sample care costs:

•	
Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
· 1	
Total	\$7,540
· •	\$7,540
Total	\$7,540 \$500
Total Patient pays:	
Total Patient pays: Deductibles	\$500
Total Patient pays: Deductibles Copays	\$500 \$200
Total Patient pays: Deductibles Copays Coinsurance	\$500 \$200 \$0

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

Amount owed to providers: \$5,400

Plan pays \$4,020

Coverage Period:

Coverage for: Individual/Family | Plan Type:HMO

Patient pays \$1,380

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$900
Laboratory tests	\$500
Vaccines, other preventive	\$40
Total	\$5,400

Patient pays:

Deductibles	\$500
Copays	\$800
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$1,380

Coverage Examples

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from innetwork <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Examples helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in outof-pocket costs, such as <u>copayments</u>, <u>deductibles</u>, and <u>coinsurance</u>. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.