



**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.IlliniCare.com/> or by calling 855-745-5507, TTY/TDD 866-565-8576

| Important Questions                                       | Answers                                                                                                      | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                   | <b>\$3,500</b> individual / <b>\$7,000</b> family.<br>Does not apply to preventive care.                     | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy plan or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .                                                                                        |
| Are there other <u>deductibles</u> for specific services? | No.                                                                                                          | You don't have to meet <b>deductibles</b> 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-pocket-limit</u> on my expenses?    | Yes, for network providers <b>\$7,150</b> individual/ <b>\$14,300</b> family. No, for non-network providers. | The <b>out-of-pocket limit</b> 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 non-network services this plan doesn't cover.                          | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .                                                                                                                                                                                                                                                                                                                                                                      |
| 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 of providers</u> ?        | Yes. See <a href="#">Find a Provider</a> or call 1-855-745-5507 for a list of participating providers.       | If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| Do I need a referral to see a <u>specialist</u> ?         | No, you don't need a referral to see a network specialist.                                                   | You can see the <b>specialist</b> you choose without permission from this plan; however, prior authorization is required from this plan.                                                                                                                                                                                                                                                                                                                          |
| Are there services this plan doesn't cover?               | Yes                                                                                                          | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .                                                                                                                                                                                                                                                                                                   |

**Questions:** Call 855-745-5507, TTY/TDD 866-565-8576 or visit us at <http://Ambetter.IlliniCare.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](http://www.cciio.cms.gov) or call 855-745-5507, TTY/TDD 866-565-8576 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount** you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**).
- 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 In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------|-------------------------------------------------|--------------------------|
| If you visit a health care <b>provider's</b> office or clinic                                                                                                              | Primary care visit to treat an injury or illness | \$30 Copay/visit                            | Not covered                                     | -----None-----           |
|                                                                                                                                                                            | Specialist visit                                 | \$65 Copay/visit                            | Not covered                                     | Prior approval required. |
|                                                                                                                                                                            | Other practitioner office visit                  | \$30 Copay/visit                            | Not covered                                     | -----None-----           |
|                                                                                                                                                                            | Preventive care/screening/immunization           | No charge                                   | Not covered                                     | -----None-----           |
| If you have a test                                                                                                                                                         | Diagnostic test (x-ray, blood work)              | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required. |
|                                                                                                                                                                            | Imaging (CT/PET scans, MRIs)                     | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required. |
| If you need drugs to treat your illness or condition<br><br>More information about <b>prescription drug coverage</b> is available at <a href="#">Preferred Drug List</a> . | Generic drugs                                    | \$15 Copay                                  | Not covered                                     | -----None-----           |
|                                                                                                                                                                            | Preferred brand drugs                            | \$50 Copay                                  | Not covered                                     | Prior approval required. |
|                                                                                                                                                                            | Non-preferred brand drugs                        | \$100 Copay                                 | Not covered                                     |                          |
|                                                                                                                                                                            | Specialty drugs                                  | 40% Coinsurance                             | Not covered                                     |                          |
| If you have outpatient surgery                                                                                                                                             | Facility fee (e.g., ambulatory surgery center)   | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required. |
|                                                                                                                                                                            | Physician/surgeon fees                           | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required. |

| 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                                                       |
|------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------|
| If you need immediate medical attention                                | Emergency room services                      | \$400 Copay after deductible                | \$400 Copay after deductible                    | -----None-----                                                                 |
|                                                                        | Emergency medical transportation             | 20% Coinsurance after deductible            | 20% Coinsurance after deductible                | -----None-----                                                                 |
|                                                                        | Urgent care                                  | \$75 Copay                                  | Not covered                                     | -----None-----                                                                 |
| If you have a hospital stay                                            | Facility fee (e.g., hospital room)           | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                                                       |
|                                                                        | Physician/surgeon fee                        | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                                                       |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$30 Copay                                  | Not covered                                     | Prior approval required.                                                       |
|                                                                        | Mental/Behavioral health inpatient services  | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                                                       |
|                                                                        | Substance use disorder outpatient services   | \$30 Copay                                  | Not covered                                     | Prior approval required.                                                       |
|                                                                        | Substance use disorder inpatient services    | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                                                       |
| If you are pregnant                                                    | Prenatal and postnatal care                  | \$30 Copay                                  | Not covered                                     | Prior approval required.                                                       |
|                                                                        | Delivery and all inpatient services          | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                                                       |
| If you need help recovering or have other special health needs         | Home health care                             | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                                                       |
|                                                                        | Rehabilitation services                      | 20% Coinsurance after deductible            | Not covered                                     | Prior authorization required. 60 visits per year. Combined with PT, OT, and ST |
|                                                                        | Habilitation services                        | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                                                       |
|                                                                        | Skilled nursing care                         | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                                                       |
|                                                                        | Durable medical equipment                    | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                                                       |
|                                                                        | Hospice service                              | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                                                       |

| 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 |
|----------------------------------------|-----------------------|---------------------------------------------|-------------------------------------------------|--------------------------|
| If your child needs dental or eye care | Eye exam              | \$0 Copay/visit                             | Not covered                                     | 1 Visit per year         |
|                                        | Glasses               | \$0 Copay/visit                             | Not covered                                     | 1 Item per year          |
|                                        | Dental check-up       | Not covered                                 | Not covered                                     | -----None-----           |

## 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.)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Long-term care
- Weight loss programs
- Acupuncture
- Non-emergency care when traveling outside the U.S.
- Dental care (Adult)
- Routine eye care (Adult)

### 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.)

- Bariatric surgery
- Hearing aids (Coverage for bone anchored hearing aids and cochlear implants only)
- Routine foot care (For diabetes treatment)
- Chiropractic care (Limited to 25 specialists' visits per benefit period)
- Infertility treatment (See policy for coverage details)
- Cosmetic Surgery
- Private-duty nursing (On an outpatient basis)

## 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 855-745-5507, TTY/TDD 866-565-8576. You may also contact your state insurance department at Illinois Department of Insurance, 320 W. Washington, 4th Floor, Springfield, IL 62767, Phone No. (217) 782-4515.

## 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: Illinois Department of Insurance, 320 W. Washington, 4th Floor, Springfield, IL 62767, Phone No. (217) 782-4515.

Additionally, a consumer assistance program can help you file your appeal. Contact (877) 527-9431

## 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 does provide 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 does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 855-745-5507, TTY/TDD 866-565-8576

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-745-5507 (TDD/TTY: 866-565-8576).

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 855-745-5507 (TDD/TTY: 866-565-8576).

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

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## 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.



### This is not a cost estimator.

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** \$3,490
- **Patient pays** \$4,050

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays

|                      |                |
|----------------------|----------------|
| Deductibles          | \$3,500        |
| Copays               | \$50           |
| Coinsurance          | \$300          |
| Limits or exclusions | \$200          |
| <b>Total</b>         | <b>\$4,050</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$2,320
- **Patient pays** \$3,080

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays

|                      |                |
|----------------------|----------------|
| Deductibles          | \$2,400        |
| Copays               | \$600          |
| Coinsurance          | \$0            |
| Limits or exclusions | \$80           |
| <b>Total</b>         | <b>\$3,080</b> |

## 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 in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Examples helps you see how **deductibles**, **copayments**, and **coinsurance** 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 out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. 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.

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## Statement of Non-Discrimination

Ambetter Insured by Celtic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter Insured by Celtic does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter Insured by Celtic:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ambetter Insured by Celtic at 1-855-745-5507 (TTY/TDD 1-866-565-8576).

If you believe that Ambetter Insured by Celtic has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Complaints and Grievance Coordinator, 999 Oakmont Plaza Drive, Suite 400, Westmont, IL 60559, 1-855-745-5507 (TTY/TDD 1-866-565-8576), Fax 1-855-519-5699. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter Insured by Celtic is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

|          |                                                                                                                                                                                                                                                                                 |
|----------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Spanish  | Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Ambetter Insured by Celtic, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-745-5507 (TTY/TDD 1-866-565-8576).              |
| Polish   | Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Ambetter Insured by Celtic, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-855-745-5507 (TTY/TDD 1-866-565-8576)                        |
| Chinese  | 如果您，或是您正在協助的對象，有關於 Ambetter Insured by Celtic 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-855-745-5507 (TTY/TDD 1-866-565-8576)。                                                                                                                                                    |
| Korean   | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter Insured by Celtic 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-745-5507 (TTY/TDD 1-866-565-8576) 로 전화하십시오.                                                                                       |
| Tagalog  | Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter Insured by Celtic, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-745-5507 (TTY/TDD 1-866-565-8576). |
| Arabic   | إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Ambetter Insured by Celtic ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب 1-855-745-5507 (TTY/TDD 1-866-565-8576).                                                             |
| Russian  | Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Ambetter Insured by Celtic, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-745-5507 (TTY/TDD 1-866-565-8576).    |
| Gujarati | જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમાંથી કોઇને Ambetter Insured by Celtic વિશે પ્રશ્નો હોય તો તમને મદદ અને માહિતી મેળવવાનો અધિકાર છે. તે ખર્ચ વિના તમારી ભાષામાં પ્રાપ્ત કરી શકાય છે. દુભાષિયો વાત કરવા માટે 1-855-745-5507 (TTY/TDD 1-866-565-8576) પર કોલ કરો.            |
| Urdu     | اگر آپ کسی کو مدد دے رہے ہیں اور آپ دونوں کو سوال ہے Ambetter Insured by Celtic کے بارے میں، تو آپ دونوں کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ ترجمان سے بات کرنے کے لیے، 1-855-745-5507 (TTY/TDD 1-866-565-8576) فون کریں۔                                  |

|            |                                                                                                                                                                                                                                                                                        |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Vietnamese | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter Insured by Celtic, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-745-5507 (TTY/TDD 1-866-565-8576).                     |
| Italian    | Se tu o qualcuno che stai aiutando avete domande su Ambetter Insured by Celtic, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-855-745-5507 (TTY/TDD 1-866-565-8576).                                  |
| Hindi      | यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्त के Ambetter Insured by Celtic के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िभाषण से बात करने े के लिए ,1-855-745-5507 (TTY/TDD 1-866-565-8576) पर किों करें।       |
| French     | Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Ambetter Insured by Celtic, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-855-745-5507 (TTY/TDD 1-866-565-8576).    |
| Greek      | Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Ambetter Insured by Celtic , έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-855-745-5507 (TTY/TDD 1-866-565-8576).                           |
| German     | Falls Sie oder jemand, dem Sie helfen, Fragen zum Ambetter Insured by Celtic haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-745-5507 (TTY/TDD 1-866-565-8576) an. |