The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, 877-687-1186, TTY/TDD 877-941-9234. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.http://ambetter.celticarehealthplan.com or call 877-687-1186, TTY/TDD 877-941-9234 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** individual / **$2,000** family. Does not apply to preventive care.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	Yes, for network: **$4,650** individual/**$9,300** family. No, for non-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.http://ambetter.celticarehealthplan.com/findadoc** or call **877-687-1186** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No, you don't need a referral to see a network specialist.	You can see the specialist you choose without a referral; however, prior authorization is required from this plan.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 Copay/visit	Not Covered	-----None-----
	Specialist visit	$45 copay/visit	Not Covered	Prior approval required
	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
	Imaging (CT/PET scans, MRIs)	$200 Copay after deductible	Not Covered	Prior approval required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.http://ambetter.celticarehealthplan.com/2018formulary	Generic drugs (Tier 1)	$20 Copay	Not Covered	-----None-----
	Preferred brand drugs (Tier 2)	$30 Copay	Not Covered	Prior approval required
	Non-preferred brand drugs (Tier 3)	$50 Copay	Not Covered	Prior approval required.
	Specialty drugs (Tier 4)	$50 Copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 Copay after deductible	Not Covered	Prior approval required
	Physician/surgeon fees	No charge after deductible	Not Covered	Prior approval required
If you need immediate medical attention	Emergency room care	$150 Copay after deductible	$150 Copay after deductiblet	-----None-----
	Emergency medical transportation	$150 Copay after deductible	$150 Copay after deductible	-----None-----
	Urgent care	$45 Copay/visit	Not Covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 Copay per stay after deductible	Not Covered	Prior approval required
	Physician/surgeon fees	No charge after deductible	Not Covered	Prior approval required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay/visit	Not Covered	Prior approval required
	Inpatient services	$500 Copay per stay after deductible	Not Covered	Prior approval required
If you are pregnant	Office visits	$30 Copay/visit	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge after deductible	Not Covered	
	Childbirth/delivery facility services	$500 Copay per stay after deductible	Not Covered	
If you need help recovering or have other special health needs	Home health care	$45 Copay	Not Covered	Prior approval required.
	Rehabilitation services	$45 Copay/visit	Not Covered	Prior approval required. 60 visits per year. Combined with PT and OT. (Limits do not apply to speech Therapy)
	Habilitation services	$45 Copay	Not Covered	Prior approval required. 60visits per person per benefit year. Benefit limits do not apply to Autism Spectrum, Home Health, and Speech/Hearing Disorders.
	Skilled nursing care	$500 Copay per stay after deductible	Not Covered	Prior approval required. 100 days per person per benefit year in a facility.
	Durable medical equipment	20% Coinsurance after deductible	Not Covered	Prior approval required.
	Hospice services	$500 Copay per stay after deductible	Not Covered	Prior approval required.
If your child needs dental or eye care	Children's eye exam	$0 Copay/visit	Not covered	1 Visit(s) per Year
	Children's glasses	$0 Copay/visit	Not covered	1 Item(s) per Year
	Children's dental check-up	No charge	Not covered	One complete initial oral exam, two periodic oral exams annually.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion (Not limited based on federal funding)
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 for one hearing aid for each hearing impaired ear for members 21 years of age or younger)
- Infertility treatment (See policy for coverage details)
- Routine foot care (For diabetes treatment)
- Weight loss programs ($150 reimbursement per contract per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Massachusetts Division of Insurance, 1000 Washington St, Suite 810 Boston, MA 02118-6200, Phone No. (877)-563-4467. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 877-687-1186, TTY/TDD 877-941-9234.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-687-1186, TTY/TDD 877-941-9234.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 877-687-1186, TTY/TDD 877-941-9234.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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 section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$45
Hospital (facility) copayment	$500
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$45
Hospital (facility) copayment	$500
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,700
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,060**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$45
Hospital (facility) copayment	$500
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$800
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,820**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.