




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](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 <a href="#">deductible</a> ?	<b>\$2,000</b> individual / <b>\$4,000</b> family. Does not apply to preventive care.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Yes, for network: <b>\$6,800</b> individual/ <b>\$13,600</b> family. No, for non-network providers.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://ambetter.celticarehealthplan.com/findadoc">www.http://ambetter.celticarehealthplan.com/findadoc</a> or call 877-687-1186 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <u>Copay</u> /visit	Not Covered	-----None-----
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	Not Covered	Prior approval required
	<u>Preventive care/screening/immunization</u>	No charge	Not Covered	-----None-----
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$25 Copay after deductible	Not Covered	Prior approval required
	Imaging (CT/PET scans, MRIs)	\$500 Copay after deductible	Not Covered	Prior approval required
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.ambetter.celticarehealthplan.com/2018formulary">www.ambetter.celticarehealthplan.com/2018formulary</a>	Generic drugs (Tier 1)	\$20 <u>Copay</u>	Not Covered	-----None-----
	Preferred brand drugs (Tier 2)	\$60 <u>Copay</u>	Not Covered	Prior approval required
	Non-preferred brand drugs (Tier 3)	\$90 <u>Copay</u>	Not Covered	Prior approval required.
	<u>Specialty drugs</u> (Tier 4)	\$90 <u>Copay</u>	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$750 Copay after deductible	Not Covered	Prior approval required
	Physician/surgeon fees	No charge after deductible	Not Covered	Prior approval required
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$700 Copay after deductible	\$700 Copay after deductible	-----None-----
	<u>Emergency medical transportation</u>	\$700 Copay after deductible	\$700 Copay after deductible	-----None-----
	<u>Urgent care</u>	\$50 <u>Copay</u> /visit	Not Covered	-----None-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1,000 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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 <a href="#">Copay</a> /visit	Not Covered	Prior approval required
	Inpatient services	\$1,000 Copay per stay after deductible	Not Covered	Prior approval required
<b>If you are pregnant</b>	Office visits	\$30 <a href="#">Copay</a> /visit	Not Covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> 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	\$1,000 Copay per stay after deductible	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$50 <a href="#">Copay</a>	Not Covered	Prior approval required.
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">Copay</a> /visit	Not Covered	Prior approval required. 60 visits per year. Combined with PT and OT. (Limits do not apply to speech Therapy)
	<a href="#">Habilitation services</a>	\$50 <a href="#">Copay</a>	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.
	<a href="#">Skilled nursing care</a>	\$1,000 Copay per stay after deductible	Not Covered	Prior approval required. 100 days per person per benefit year in a facility.
	<a href="#">Durable medical equipment</a>	20% Coinsurance after deductible	Not Covered	Prior approval required.
	<a href="#">Hospice services</a>	\$1,000 Copay per stay after deductible	Not Covered	Prior approval required.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$0 <a href="#">Copay</a> /visit	Not covered	1 Visit(s) per Year
	Children's glasses	\$0 <a href="#">Copay</a> /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
- Long-term care
- Routine eye care (Adult)
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Dental care (Adult)
- Private-duty nursing

#### 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)
- Hearing aids (\$2,000 for one hearing aid for each hearing impaired ear for members 21 years of age or younger)
- Weight loss programs (\$150 reimbursement per contract per calendar year)
- Bariatric surgery
- Infertility treatment (See policy for coverage details)
- Chiropractic care
- Routine foot care (For diabetes treatment)

**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](http://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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$1,000
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,540</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$2,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,160</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$1,000
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$2,100
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,860</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$1,000
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$2,500
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$3,120</b>