Ambetter from Coordinated Care Corporation: Ambetter Balanced Care 3 (2017)

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

Coverage Period: 01/01/2017 - 12/31/2017

Coverage for: Individual/Family | Plan Type: HMO

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.coordinatedcarehealth.com/** or by calling **877-687-1197, TTY/TDD 877-941-9238**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,250** individual / **$2,500** family. Does not apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy plan or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket-limit on my expenses?	Yes, for network providers **$5,700** individual/**$11,400** family. No, for non-network providers.	The **out-of-pocket limit** 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 out–of–pocket limit?	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 **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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See Find a Provider or call **1-877-687-1197** 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 specialist?	Yes	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
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 **excluded services**.

Questions: Call **877-687-1197, TTY/TDD 877-941-9238** or visit us at **http://ambetter.coordinatedcarehealth.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 **877-687-1197, TTY/TDD 877-941-9238** 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 provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay/visit	Not covered	-----None-----
	Specialist visit	$50 Copay/visit	Not covered	-----None-----
	Other practitioner office visit	$25 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)	30% Coinsurance after deductible	Not covered	Prior approval required.
	Imaging (CT/PET scans, MRIs)	30% Coinsurance 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 Preferred Drug List .	Generic drugs	$25 Copay	Not covered	-----None-----
	Preferred brand drugs	$50 Copay	Not covered	Prior approval required.
	Non-preferred brand drugs	30% Coinsurance after deductible	Not covered	Prior approval required. Subject to deductible
	Specialty drugs	30% Coinsurance after deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after deductible	Not covered	Prior approval required.
	Physician/surgeon fees	30% 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	$600 Copay before deductible	$600 Copay before deductible	In-network facilities may provide services from out-of-network providers. For out-of-network emergency services, you may be responsible for the difference between the provider's billed charges and the plan's allowed amount. (See note on balance billing above this chart.)
	Emergency medical transportation	30% Coinsurance after deductible	30% Coinsurance after deductible	In-network facilities may provide services from out-of-network providers. For out-of-network emergency services, you may be responsible for the difference between the provider's billed charges and the plan's allowed amount. (See note on balance billing above this chart.)
	Urgent care	$75 Copay	Not covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 Copay per day before deductible	Not covered	Prior approval required
	Physician/surgeon fee	30% Coinsurance after deductible	Not covered	Prior approval required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 Copay	Not covered	Prior approval required.
	Mental/Behavioral health inpatient services	$750 Copay per day before deductible	Not covered	Prior approval required.
	Substance use disorder outpatient services	$25 Copay	Not covered	Prior approval required.
	Substance use disorder inpatient services	$750 Copay per day before deductible	Not covered	Prior approval required
If you are pregnant	Prenatal and postnatal care	$25 Copay	Not covered	-----None-----
	Delivery and all inpatient services	$750 Copay per day before 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 help recovering or have other special health needs	Home health care	30% Coinsurance after deductible	Not covered	130 Visit(s) per Year
	Rehabilitation services	30% Coinsurance after deductible	Not covered	25 visits combined per year (Inpatient Rehabilitation limited to 30 days per calendar year)
	Habilitation services	30% Coinsurance after deductible	Not covered	25 Outpatient visits per benefit per year. 30 Inpatient days per benefit per year
	Skilled nursing care	30% Coinsurance after deductible	Not covered	60 days per year in a facility
	Durable medical equipment	30% Coinsurance after deductible	Not covered	Prior approval required.
	Hospice service	30% Coinsurance after deductible	Not covered	Respite Care - 14 days per lifetime
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. 1 pair of lenses or 1 pair frames 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.)**

- Bariatric surgery
- Long-term care
- Routine foot care (Not related to diabetes treatment)
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Dental care (Adult)
- Private-duty nursing

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 (Not limited based on federal funding)
- Hearing aids (Coverage for cochlear implants only)
- Acupunture (Limited to 12 visits per year. Unlimited visits for chemical dependency treatment)
- Chiropractic care (Limited to 10 specialists' visits per year)
- Routine foot care (For diabetes treatment)

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.)
• Infertility treatment (Coverage for the diagnosis of infertility only)

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 877-687-1197, TTY/TDD 877-941-9238. You may also contact your state insurance department at Consumer Advocacy/SHIBA Office of the Insurance Commissioner, 5000 Capitol Blvd., SE, Turnwater, WA 98501, Phone No. (800) 562-6900 or (360) 725-7080

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: Consumer Advocacy/SHIBA Office of the Insurance Commissioner, 5000 Capitol Blvd., SE, Turnwater, WA 98501, Phone No. (800) 562-6900 or (360) 725-7080

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 877-687-1197, TTY/TDD 877-941-9238
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-687-1197 (TDD/TTY: 877-941-9238).
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 877-687-1197 (TDD/TTY: 877-941-9238).

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

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** $5,290
- **Patient pays** $2,250

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
Total	**$7,540**

Patient pays

Deductibles	$1,250
Copays	$800
Coinsurance	$0
Limits or exclusions	$200
Total	**$2,250**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,670
- **Patient pays** $2,730

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
Total	**$5,400**

Patient pays

Deductibles	$1,250
Copays	$1,100
Coinsurance	$300
Limits or exclusions	$80
Total	**$2,730**

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.

Statement of Non-Discrimination

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

Ambetter from Coordinated Care:

- 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 from Coordinated Care at 1-877-687-1197 (TTY/TDD 1-877-941-9238).

If you believe that Ambetter from Coordinated Care 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: Grievances Coordinator Coordinated Care, 1145 Broadway, Suite 300, Tacoma, WA 98402, 1-877-687-1197 (TTY/TDD 1-877-941-9238), Fax 1-855-218-0588. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Coordinated Care 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 from Coordinated Care, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-678-1197 (TTY/TDD 1-877-941-9238).
Chinese	如果您，或是您正在協助的對象，有關於 Ambetter from Coordinated Care 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 1-877-678-1197 (TTY/TDD 1-877-941-9238)。
Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Coordinated Care, 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 1-877-678-1197 (TTY/TDD 1-877-941-9238).
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Coordinated Care 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-678-1197 (TTY/TDD 1-877-941-9238) 로 전화하십시오.
Russian	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Ambetter from Coordinated Care, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-678-1197 (TTY/TDD 1-877-941-9238).
Tagalog	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Coordinated Care, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-678-1197 (TTY/TDD 1-877-941-9238).
Ukrainian	Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Ambetter from Coordinated Care, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 1-877-678-1197 (TTY/TDD 1-877-941-9238).
Cambodian, Mon-Khmer	ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងតែជួយ មានសំណួរអំពី Ambetter from Coordinated Care ទេ, អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន នៅក្នុងភាសា របស់អ្នក ដោយមិនអស់ប្រាក់ ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូម 1-877-678-1197 (TTY/TDD 1-877-941-9238) ។
Japanese	ご本人様、またはお客様の身の回りの方でも、Ambetter from Coordinated Careについてご質問がございました ら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。 通訳とお話される場合、1-877-678-1197 (TTY/TDD 1-877-941-9238)までお電話ください

Amharic	እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Ambetter from Coordinated Care ጥያቄ ካላቸሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-877-678-1197 (TTY/TDD 1-877-941-9238) ይደውሉ።
Cushite-Oromo	Isin yookan namni biraa isin deeggartan Ambetter from Coordinated Care irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-678-1197 (TTY/TDD 1-877-941-9238) tiin bilbilaa.
Arabic	إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Ambetter from Coordinated Care ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب (TTY/TDD 1-877-941-9238) 1-877-678-1197.
Punjabi	ਜੇ ਤੁਹਾਨ ੂੰ , ਜਾਂ ਤੁਸੀ ਜਜਸ ਦੀ ਮਦਦ ਕਰ ਰਹੇ ਹੋ , Ambetter from Coordinated Care ਕੋਈ ਸਵਾਲ ਹੈ ਤਾਂ, ਤੁਹਾਨ ੂੰ ਜਿਨਾ ਜਕਸੇ ਕੀਮਤ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਜਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ . ਦੁਭਾਸੀਏ ਨਾਲ ਗਿੱਲ ਕਰਨ ਲਈ, 1-877-678-1197 (TTY/TDD 1-877-941-9238) ਤੇ ਕਾਲ ਕਰੋ
German	Falls Sie oder jemand, dem Sie helfen, Fragen zum Ambetter from Coordinated Care 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 1-877-678-1197 (TTY/TDD 1-877-941-9238) an.
Laotian	ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກ່າລັງຊ່ວຍເຫຼືອ, ມີຄ່າຖາມກ່ຽວກັບ Ambetter from Coordinated Care, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນ ຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-877-678-1197 (TTY/TDD 1-877-941-9238).