



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.mhsindiana.com/> or by calling 877-687-1182, TTY/TDD 800-743-3333

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$450 individual / \$900 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 <u>deductibles</u> 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 <u>out-of-pocket-limit</u> on my expenses?	Yes, for network providers \$2,250 individual/ \$4,500 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 <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 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 of providers</u> ?	Yes. See Find a Provider or call 1-877-687-1182 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> ?	No, you don't need a referral to see a network specialist.	You can see the specialist 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 excluded services .

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- **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	\$1 Copay/visit	Not covered	-----None-----
	Specialist visit	\$10 Copay/visit	Not covered	Prior approval required.
	Other practitioner office visit	\$1 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 More information about prescription drug coverage is available at Preferred Drug List .	Generic drugs	\$5 Copay	Not covered	-----None-----
	Preferred brand drugs	\$25 Copay	Not covered	Prior approval required.
	Non-preferred brand drugs	20% Coinsurance after deductible	Not covered	Prior approval required. Subject to deductible
	Specialty drugs	20% Coinsurance after deductible	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	20% Coinsurance after deductible	20% Coinsurance after deductible	-----None-----
	Emergency medical transportation	20% Coinsurance after deductible	20% Coinsurance after deductible	-----None-----
	Urgent care	\$50 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	\$1 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	\$1 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	\$1 Copay	Not covered	Prior approval required.
	Delivery and all inpatient services	20% Coinsurance after deductible	Not covered	Prior authorization required. 48 hour minimum stay.
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	Not covered	Prior authorization required. 100 visits per benefit period.
	Rehabilitation services	20% Coinsurance after deductible	Not covered	Prior authorization required. 60 visits per year, 20 visits per benefit per year.
	Habilitation services	20% Coinsurance after deductible	Not covered	Prior authorization required. 60 visits per benefit period.
	Skilled nursing care	20% Coinsurance after deductible	Not covered	Prior authorization required. 90 days per year in a facility.
	Durable medical equipment	20% Coinsurance after deductible	Not covered	Prior authorization required.
	Hospice service	20% Coinsurance after deductible	Not covered	Prior authorization 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)
- Cosmetic surgery
- Long-term care
- Weight loss programs
- Acupuncture
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Bariatric surgery
- Infertility treatment
- Routine foot care (Not related to 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.)

- Chiropractic care (Limited to 12 specialists' visits per year)
- Routine eye care (Adult)
- Dental care (Adult)
- Private-duty nursing (On an outpatient basis - limited to 82 visits per year)

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 877-687-1182, TTY/TDD 800-743-3333. You may also contact your state insurance department at Indiana Department of Insurance, 311 West Washington Street, Suite 100, Indianapolis, IN, 46204, Phone No. (317) 232-2385 or (800) 622-4461.

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: Indiana Department of Insurance, 311 West Washington Street, Suite 100, Indianapolis, IN, 46204, Phone No. (317) 232-2385 or (800) 622-4461.

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 877-687-1182, TTY/TDD 800-743-3333

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-687-1182 (TDD/TTY 1-800-743-3333).

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 877-687-1182 (TDD/TTY 1-800-743-3333).

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** \$5,980
- **Patient pays** \$1,560

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	\$450
Copays	\$10
Coinsurance	\$900
Limits or exclusions	\$200
Total	\$1,560

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

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,470
- **Patient pays** \$930

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	\$450
Copays	\$200
Coinsurance	\$200
Limits or exclusions	\$80
Total	\$930

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

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Ambetter from MHS:

- 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 MHS at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

If you believe that Ambetter from MHS 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: Grievance and Appeals Coordinator, 1099 N Meridian Street, Suite 400, Indianapolis, IN 46204, 1-877-687-1182 (TTY/TDD 1-800-743-3333), Fax 1-866-714-7993. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from MHS 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>.

Japanese	ご本人様、またはお客様の身の回りの方でも、Ambetter from MHS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、1-877-687-1182 (TTY/TDD 1-800-743-3333)までお電話ください
Dutch	Als u, of iemand die u helpt, vragen heeft over Ambetter from MHS, heeft u het recht om hulp en informatie te krijgen in uw taal zonder kosten. Om te praten met een tolk, bel 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Tagalog	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from MHS, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Russian	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Ambetter from MHS, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Punjabi	ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਤੁਸੀਂ ਜਜ਼ਮ ਦੀ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, Ambetter from MHS ਕੋਈ ਸਵਾਲ ਹੈ ਤਾਂ, ਤੁਹਾਨੂੰ ਜਿਨ੍ਹਾਂ ਜਕਸੇ ਕੀਮਤ 'ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਜਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ. ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗਿੱਲ ਕਰਨ ਲਈ, 1-877-687-1182 (TTY/TDD 1-800-743-3333) ਤੇ ਕਾਲ ਕਰੋ
Hindi	यदि आपके, या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Ambetter from MHS के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में सुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िभाषण से बात करन े के लिए, 1-877-687-1182 (TTY/TDD 1-800-743-3333) पर किँ करें।