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, visit https://ambetter.mhsindiana.com/2018-brochures.html, or call 1-877-687-1182 (TTY/TDD 1-800-743-3333). 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 https://www.healthcare.gov/sbc-glossary or call 1-877-687-1182 (TTY/TDD 1-800-743-3333) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$6,500 individual/$13,000 family.	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, primary care, specialist, and urgent care office visits, generic and preferred drugs 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network $6,500 individual/$13,000 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?	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 Find a Provider or call 1-877-687-1182 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 can see the specialist you choose without a referral.

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		Limitation, 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; deductible does not apply.	Not covered	-----None-----
	Specialist visit	$60 Copay/visit; deductible does not apply.	Not covered	Prior authorization required. Failure to obtain prior authorization for any service that requires prior authorization may result in denial of payment for care that may otherwise be covered.
	Preventive care/ screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	Not covered	Prior authorization required.
	Imaging(CT/PET scans, MRIs)	No charge after deductible	Not covered	Prior authorization required.

Common Medical Event	Services You May Need	What You will Pay		Limitation, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Preferred Drug List.	Generic Drugs (Tier 1)	Retail: $15 Copay/prescription; Mail order: $45 Copay/prescription; deductible does not apply	Not covered	None. Prescription drugs are provided up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3X retail cost-sharing amount.
	Preferred brand drugs (Tier 2)	Retail: $50 Copay/prescription; Mail order: $150 Copay/prescription; deductible does not apply	Not covered	Prior authorization required. Prescription drugs are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3X retail cost-sharing amount.
	Non-preferred brand drugs (Tier 3)	No charge after deductible	Not covered	Prior authorization required. Prescription drugs are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3X retail cost-sharing amount.
	Specialty drugs (Tier 4)	No charge after deductible	Not covered	Prior authorization required. Prescription drugs are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3X retail cost-sharing amount.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge after deductible	Not covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	No Charge after deductible	No Charge after deductible	-----None-----
	Emergency Medical transportation	No charge after deductible	No charge after deductible	-----None-----
	Urgent Care	$100 Copay/visit: deductible does not apply	Not covered	-----None-----

Common Medical Event	Services You May Need	What You will Pay		Limitation, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge after deductible	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay/office visit; deductible does not apply; No charge after deductible for all other outpatient services	Not covered	Prior authorization required. (PCP and Other Practitioner visits do not require prior authorization)
	Inpatient services	No charge after deductible	Not covered	Prior authorization required.
If you are pregnant	Office visits	$30 Copay/visit; deductible does not apply	Not covered	Prior authorization required. Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance, copayment and/or deductible 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	Prior authorization required. Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance, copayment and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	No charge after deductible	Not covered	Prior authorization required. Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance, copayment and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

Common Medical Event	Services You May Need	What You will Pay		Limitation, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Prior authorization required. 100 visits per benefit period.
	Rehabilitation services	No charge after deductible	Not covered	Prior authorization required. 60 visits per year, 20 visits per benefit per year.
	Habilitation services	No charge after deductible	Not covered	Prior authorization required. 60 visits per benefit period.
	Skilled nursing care	No charge after deductible	Not covered	Prior authorization required. 90 days per year in a facility.
	Durable medical equipment	No charge after deductible	Not covered	Prior authorization required.
	Hospice services	No charge after deductible	Not covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	$0 Copay/visit; deductible does not apply	Not covered	1 Visit per Year
	Children's glasses	$0 Copay/item; deductible does not apply	Not covered	1 Item per Year
	Children's dental check-up	Not covered	Not covered	-----None-----

Excluded Services & Other Covered Services

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

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care (Limited to 12 specialists' visits per year)	• Dental care (Adult)	• Private-duty nursing (On an outpatient basis-limited to 82 visits per year)
• Routine eye care (Adult)	• Routine foot care (Related to 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: Indiana Department of Insurance, 311 West Washington Street, Suite 100, Indianapolis, IN, 46204, Phone No. (317) 232-2385 or (800) 622-4461. 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: Indiana Department of Insurance, 311 West Washington Street, Suite 100, Indianapolis, IN, 46204, Phone No. (317) 232-2385 or (800) 622-4461.

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 the 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 1-877-687-1182, TTY/TDD 1-800-743-3333.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-687-1182, TTY/TDD 1-800-743-3333.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-687-1182, TTY/TDD 1-800-743-3333.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne 1-877-687-1182, TTY/TDD 1-800-743-3333.

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 $6,500
- Specialist copayment $60
- Hospital (facility) copayment $0
- Other coinsurance 0%

This EXAMPLE even includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery facility Services
Diagnostic test (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,560**

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible $6,500
- Specialist copayment $60
- Hospital (facility) copayment $0
- Other coinsurance 0%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,460**

Mia's Simple Fracture

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

- The plan's overall deductible $6,500
- Specialist copayment $60
- Hospital (facility) copayment $0
- Other coinsurance 0%

This EXAMPLE even 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	$1,600
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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

Statement of Non-Discrimination

Ambetter from MHS 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 MHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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*.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Sunshine Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1169 (Relay Florida 1-800-955-8770).
French Creole:	Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Ambetter from Sunshine Health, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-877-687-1169 (Relay Florida 1-800-955-8770).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Sunshine Health, 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 1-877-687-1169 (Relay Florida 1-800-955-8770).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Sunshine Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-687-1169 (Relay Florida 1-800-955-8770).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Sunshine Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-687-1169 (Relay Florida 1-800-955-8770)。
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Sunshine Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1169 (Relay Florida 1-800-955-8770).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Sunshine Health, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-687-1169 (Relay Florida 1-800-955-8770).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Sunshine Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1169 (Relay Florida 1-800-955-8770).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Sunshine Health ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1169 (Relay Florida 1-800-955-8770).
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Sunshine Health, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-877-687-1169 (Relay Florida 1-800-955-8770).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Sunshine Health hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1169 (Relay Florida 1-800-955-8770) an.
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Sunshine Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1169 (Relay Florida 1-800-955-8770) 로 전화하십시오.
Polish:	Jeżeli ty lub osoba, której pomagasz, macie pytania na temat planów za pośrednictwem Ambetter from Sunshine Health, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-877-687-1169 (Relay Florida 1-800-955-8770).
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from Sunshine Health વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-877-687-1169 (Relay Florida 1-800-955-8770) ઉપર કૉલ કરો.
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีค าถามเกี่ยวกับ Ambetter from Sunshine Health ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้ บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-877-687-1169 (Relay Florida 1-800-955-8770)