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.HomeStateHealth.com/2018-brochures.html, or call 1-855-650-3789 (TTY/TDD 1-877-250-6113). 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 1-855-650-3789 (TTY/TDD 1-877-250-6113) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$675 individual/$1,350 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?	$2,450 individual/$4,900 family	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 1-855-650-3789 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	$0 Copay/visit; deductible does not apply.	Not Covered	-----None-----
	Specialist visit	$5 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)	30% Coinsurance	Not covered	Prior authorization required.
	Imaging(CT/PET scans, MRIs)	30% Coinsurance	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)	No Charge	Not covered	Prescription drugs are provided up to 34 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: $25 Copay/prescription; Mail order: $75 Copay/prescription; deductible does not apply	Not covered	Prior authorization required. Subject to deductible.
	Non-preferred brand drugs (Tier 3)	30% Coinsurance	Not covered	Prior authorization required. Subject to deductible.
	Specialty drugs (Tier 4)	30% Coinsurance	Not covered	Prior authorization required. Subject to deductible.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	Not covered	Prior authorization required.
	Physician/surgeon fees	30% Coinsurance	Not covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	$100 Copay before deductible	$100 Copay before deductible	-----None-----
	Emergency Medical transportation	30% Coinsurance	30% Coinsurance	-----None-----
	Urgent Care	$10 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)	$200 Copay per day before deductible	Not covered	Prior authorization required.
	Physician/surgeon fees	30% Coinsurance	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 Copay/office visit; deductible does not apply; 30% coinsurance for all other outpatient services	Not covered	Prior authorization required. (PCP and Other Practitioner visits do not require prior authorization)
	Inpatient services	$200 Copay per day before deductible	Not covered	Prior authorization required.
If you are pregnant	Office visits	$0 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, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% Coinsurance	Not covered	Prior authorization required. Cost sharing does not apply for preventive services. Depending on the type of services, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	$200 Copay per day before deductible	Not covered	Prior authorization required. Cost sharing does not apply for preventive services. Depending on the type of services, deductible or copayment 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	30% Coinsurance	Not covered	Prior authorization required. 100 visits per year.
	Rehabilitation services	$0 Copay/visit for physical and occupational therapy; deductible does not apply; 30% coinsurance for all other services	Not covered	Prior authorization required. 20 visits per therapy per year. PT and OT (Limits do not apply to Speech Therapy).
	Habilitation services	$0 Copay/visit for physical and occupational therapy; deductible does not apply; 30% coinsurance for all other services	Not covered	Prior authorization required. 20 visits per benefit period. (Limits do not apply to Autism Services).
	Skilled nursing care	30% Coinsurance	Not Covered	Prior authorization required. 150 days per year combined with Inpatient Rehabilitation.
	Durable medical equipment	30% Coinsurance	Not covered	Prior authorization required.
	Hospice services	30% Coinsurance	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/visit; deductible does not apply	Not covered	Eyeglasses (frames) or contacts. 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
- Dental Care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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	• Hearing aids	• Infertility treatment (diagnosis only)
• Private-duty nursing (prior authorization required, limited to 82 visits a year)	• 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: Missouri Department of Insurance Phone: 573-751-4126 PO Box 690, Jefferson City, MO 65102-0690. 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: Missouri Department of Insurance Phone: 573-751-4126 PO Box 690, Jefferson City, MO 65102-0690. Additionally, a consumer assistance program can help you file your appeal. Contact 1-800-726-7390.

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 1-855-650-3789, TTY/TDD 1-877-250-6113.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-650-3789, TTY/TDD 1-877-250-6113.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-650-3789, TTY/TDD 1-877-250-6113.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne 1-855-650-3789, TTY/TDD 1-877-250-6113.

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	$675
Specialist copayment	$5
Hospital (facility) copayment	$200
Other coinsurance	30%

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	$675
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,235**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	$675
Specialist copayment	$5
Hospital (facility) copayment	$200
Other coinsurance	30%

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	$675
Copayments	$300
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,635**

Mia's Simple Fracture

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

The plan's overall deductible	$675
Specialist copayment	$5
Hospital (facility) copayment	$200
Other coinsurance	30%

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	$675
Copayments	$20
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,195**

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

Statement of Non-Discrimination

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

Ambetter from Home State Health:

- 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 Home State Health at 1-855-650-3789 (TTY/TDD 1-877-250-6113).

If you believe that Ambetter from Home State Health 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/Appeals Home State Health, 16090 Swingley Ridge Road, Suite 500, Chesterfield, MO 63017], 1-855-650-3789 (TTY/TDD 1-877-250-6113), Fax, 1-866-390-4429. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Home State Health 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 Home State Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Home State 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 1-855-650-3789 (TTY/TDD 1-877-250-6113)。
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Home State 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 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Serbo-Croatian:	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from Home State Health, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-855-650-3789 (TTY/TDD 1-877-250-6113).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Home State 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 1-855-650-3789 (TTY/TDD 1-877-250-6113) an.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Home State Health، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Home State Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-650-3789 (TTY/TDD 1-877-250-6113) 로 전화하십시오.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Home State Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-855-650-3789 (TTY/TDD 1-877-250-6113).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Home State Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Home State Health, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from Home State Health, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kawl 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Persian:	اگر شما، يا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Home State Health داريد، از اين حق برخورداريد که کمک و اطلاعات را بصورت رايگان به زبان خود دريافت کنيد. براي صحبت کردن با مترجم با شماره 1-855-650-3789 (TTY/TDD 1-877-250-6113) تماس بگيريد.
Cushite:	Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Home State Health irra gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajiin dubadhuu,1-855-650-3789 irra bilbilli (TTY/TDD 1-877-250-6113).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Home State Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Amharic:	እርስዎ ወይም እርሰዎ የሚርዱት ሰው ስለ Ambetter from Home State Health ግብር ጥያቄ ካለዎት ያለምንም ወጪ በቋንቋዎ ድጋፍ እንዲሁም መረጃ የማግኘት መብት አለዎት፤ ፤ አስተርጓሚ ለማነጋገር በ 1-855-650-3789 (TTY/TDD 1-877-250-6113) ይደውሉ፤ ፤