Coverage for: Individual/Family | Plan Type: HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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.llliniCare.com/2019-

brochures.html, or call 1-855-745-5507 (TTY/TDD: 1-844-517-3431). For general definitions of common terms, such as

<u>allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-855-745-5507 (TTY/TDD: 1-844-517-3431) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	There is no <u>deductible</u> .	There is no <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan?</u>	For <u>network providers</u> : \$1,075 individual/\$2,150 family. No, for non- <u>network providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> and health care this <u>plan</u> 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 <u>network provider</u> ?	Yes. See <u>Find a Provider</u> or call 1-855-745-5507 for a list of <u>network</u> <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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All $\underline{\text{copayment}}$ and $\underline{\text{coinsurance}}$ costs shown in this chart are after your $\underline{\text{deductible}}$ has been met, if a $\underline{\text{deductible}}$ applies.

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitation, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	No charge	Not covered	None	
If you visit a health	Specialist visit	\$10 Copay/visit	Not covered	None	
care <u>provider's</u> office or clinic	Preventive care/ screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	Not covered	Prior authorization may be required. Failure to obtain prior authorization for any service that requires prior authorization may result in reduction of benefits. See your policy for more details.	
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not covered	Prior authorization may be required.	

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitation, Exceptions, & Other Important Information	
	Generic drugs (Tier 1)	No charge	Not covered	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.	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Preferred Drug List.	Preferred brand drugs (Tier 2)	Retail: \$25 <u>Copay</u> /prescription; Mail order: \$75 <u>Copay</u> /prescription	Not covered	Prior authorization may be 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)	20% <u>Coinsurance</u>	Not covered	Prior authorization may be 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) 20% Coinsurance	Not covered	Prior authorization may be 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	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	Not covered	Prior authorization may be required.	
outpatient surgery	Physician/surgeon fees	20% Coinsurance	Not covered	Prior authorization may be required.	

		What You	ı Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitation, Exceptions, & Other Important Information	
If you need	Emergency room care	20% Coinsurance	20% Coinsurance	None	
immediate medical	Emergency Medical transportation	20% Coinsurance	20% Coinsurance	None	
attention	<u>Urgent Care</u>	\$10 <u>Copay</u> /visit	Not covered	None	
If you have a	Facility fee (e.g., hospital room)	20% Coinsurance	Not covered	Prior authorization may be required.	
hospital stay	Physician/surgeon fees	20% Coinsurance	Not covered	Prior authorization may be required.	
If you need mental		No charge/office visit;		Prior authorization may be required. (PCP and	
health, behavioral	Outpatient services	20% coinsurance for all	Not covered	other practitioner visits do not require prior	
health, or substance		other services		authorization)	
abuse services	Inpatient services	20% Coinsurance	Not covered	Prior authorization may be required.	

		What Yo	u Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitation, Exceptions, & Other Important Information	
If you are pregnant	Office visits	No charge	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery professional services	20% <u>Coinsurance</u>	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitation, Exceptions, & Other Important Information	
	Home health care	20% Coinsurance	Not covered	Prior authorization may be required.	
If you need help	Rehabilitation services	20% Coinsurance	Not covered	Prior authorization may be required. 60 Visits per year. 20 Visits per year per therapy (PT, OT, ST).	
recovering or have other special health	<u>Habilitation services</u>	20% Coinsurance	Not covered	Prior authorization may be required.	
needs	Skilled nursing care	20% Coinsurance	Not covered	Prior authorization may be required.	
liceus	Durable medical equipment	20% Coinsurance	Not covered	Prior authorization may be required.	
	Hospice services	20% Coinsurance	Not covered	Prior authorization may be required.	
If your child needs	Children's eye exam	No charge	Not covered	1 Visit per year.	
dental or eye care	Children's glasses	No charge	Not covered	1 Item per year.	
dental of eye cale	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

- 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.)

- Bariatric surgery
- Chiropractic care (Limited to 25 specialists' visits per benefit period)
- Cosmetic Surgery (Correction of congenital deformities, or conditions from accidental injuries, scars, tumors, or disease)
- Hearing aids (two items per three years.
- Infertility treatment (See policy for coverage details)
- Private-duty nursing (On an outpatient basis)
- 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: Ambetter from IlliniCare Health at 1-855-745-5507 (TTY/TDD: 1-844-517-3431); Illinois Department of Insurance, 320 W. Washington, 4th Floor, Springfield, IL 62767, Phone No. (217) 782-4515. 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 <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Illinois Department of Insurance, 320 W. Washington, 4th Floor, Springfield, IL 62767, Phone No. (217) 782-4515. Additionally, a consumer assistance program can help you file your appeal. Contact (877) 527-9431.

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 1-855-745-5507, TTY/TDD 1-844-517-3431.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-745-5507, TTY/TDD 1-844-517-3431.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-745-5507, TTY/TDD 1-844-517-3431.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-745-5507, TTY/TDD 1-844-517-3431.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage

Peg is Having a baby

(9 months of in-network prenatal care and a hospital delivery)

■ The plan's overall deductible	\$0
 Specialist copayment 	\$10
 Hospital (facility) <u>coinsurance</u> 	20%
Other coinsurance	20%

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	\$0
Copayments	\$0
Coinsurance	\$1,075
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,135

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$10
 Hospital (facility) <u>coinsurance</u> 	20%
Other <u>coinsurance</u>	20%

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	\$0	
Copayments	\$300	
Coinsurance	\$400	
What isn't covered		
Limits or exclusions	\$60	
The total Joe would pay is	\$760	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductib</u>	<u>ole</u> \$0
 Specialist copayment 	\$10
 Hospital (facility) coinsurant 	<u>ce</u> 20%
Other <u>coinsurance</u>	20%

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:

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Cost Sharing	
Deductibles	\$0
Copayments	\$30
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$330

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

Statement of Non-Discrimination

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

Ambetter from IlliniCare 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 IlliniCare Health at 1-855-745-5507 (TTY/TDD 1-844-517-3431).

If you believe that Ambetter from IlliniCare 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: Ambetter from IlliniCare Health, Attn: Appeals and Grievances, PO Box 92050, Elk Grove Village, IL 60009-2050, 1-855-745-5507 (TTY/TDD 1-844-517-3431), Fax 1-877-668-2076, Email gareferrals@centene.com. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from IlliniCare 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 from IlliniCare Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-745-5507 (TTY/TDD 1-844-517-3431).		
Polish:	Jeżeli ty lub osoba, której pomagasz, macie pytania na temat Ambetter from IlliniCare Health, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-855-745-5507 (TTY/TDD 1-844-517-3431).		
Chinese:	如果您,或是您正在協助的對象,有關於 Ambetter from IlliniCare 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 1-855-745-5507 (TTY/TDD 1-844-517-3431)。		
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from IlliniCare Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-745-5507 (TTY/TDD 1-844-517-3431)로 전화하십시오.		
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from IlliniCare Health, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-745-5507 (TTY/TDD 1-844-517-3431).		
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from IlliniCare Health، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 755-745-455. (TTY/TDD 1-844-517-3431).		
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from IlliniCare Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-855-745-5507 (ТТУ/ТDD 1-844-517-3431).		
Gujarati:	aa aaaa aaaa aaa aaa aaa aaa aaa aaaaa aaaa		
Urdu:	اگر Ambetter from IlliniCare Healthکے بارے میں آپ، یا جن کی آپ مدد کر رہے ہیں ان کے موالات ہوں تو، آپ کو بلامعاوضہ اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے، (TTY/TDD 1-844-517-3431)، پر کل کریں۔		
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from IlliniCare 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 1-855-745-5507 (TTY/TDD 1-844-517-3431).		
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from IlliniCare Health, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-855-745-5507 (TTY/TDD 1-844-517-3431).		
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from IlliniCare Health के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-855-745-5507 (TTY/TDD 1-844-517-3431) पर कॉल करें।		
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from IlliniCare Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-855-745-5507 (TTY/TDD 1-844-517-3431).		
Greek:	Εάν εσείς ή κάποιος που βοηθάτε, έχετε ερωτήσεις σχετικά με την Ambetter from IlliniCare Health, έχετε το δικαίωμα να ζητήσετε βοήθεια και πληροφορίες στη γλώσσα σας, χωρίς χρέωση. Για να μιλήσετε με διερμηνέα, καλέστε το 1-855-745-5507 (TTY/TDD 1-844-517-3431).		
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from IlliniCare Health hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen,		

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