



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.illiniCare.com/2019-brochures.html>, or call 1-855-745-5507 (TTY/TDD: 1-844-517-3431). 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 1-855-745-5507 (TTY/TDD: 1-844-517-3431) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$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 <u>deductible</u> ?	There is no <u>deductible</u> .	There is no <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> : \$1,075 individual/\$2,150 family. No, for <u>non-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 <u>out-of-pocket limit</u> ?	<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 <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="#">Find a Provider</a> or call 1-855-745-5507 for a list of <u>network 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> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	----None----
	<a href="#">Specialist</a> visit	\$10 <a href="#">Copay</a> /visit	Not covered	----None----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">Coinsurance</a>	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% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be 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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">Preferred Drug List</a> .	Generic drugs (Tier 1)	No charge	Not covered	<u>Prescription drugs</u> are provided up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail <u>cost-sharing</u> amount.
	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. <u>Prescription drugs</u> are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail <u>cost-sharing</u> amount.
	Non-preferred brand drugs (Tier 3)	20% <u>Coinsurance</u>	Not covered	Prior authorization may be required. <u>Prescription drugs</u> are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail <u>cost-sharing</u> amount.
	<a href="#">Specialty drugs</a> (Tier 4)	20% <u>Coinsurance</u>	Not covered	Prior authorization may be required. <u>Prescription drugs</u> are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail <u>cost-sharing</u> amount.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	Not covered	Prior authorization may be required.
	Physician/surgeon fees	20% <u>Coinsurance</u>	Not covered	Prior authorization may be 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 immediate medical attention	<a href="#">Emergency room care</a>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	-----None-----
	<a href="#">Emergency Medical transportation</a>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	-----None-----
	<a href="#">Urgent Care</a>	\$10 <u>Copay</u> /visit	Not covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u>	Not covered	Prior authorization may be required.
	Physician/surgeon fees	20% <u>Coinsurance</u>	Not covered	Prior authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/office visit; 20% <u>coinsurance</u> for all other services	Not covered	Prior authorization may be required. (PCP and other practitioner visits do not require prior authorization)
	Inpatient services	20% <u>Coinsurance</u>	Not covered	Prior authorization may be 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 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. <u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , <u>deductible</u> or <u>copayment</u> 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. <u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , <u>deductible</u> or <u>copayment</u> 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. <u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , <u>deductible</u> or <u>copayment</u> 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	<a href="#">Home health care</a>	20% <u>Coinsurance</u>	Not covered	Prior authorization may be required.
	<a href="#">Rehabilitation services</a>	20% <u>Coinsurance</u>	Not covered	Prior authorization may be required. 60 Visits per year. 20 Visits per year per therapy (PT, OT, ST).
	<a href="#">Habilitation services</a>	20% <u>Coinsurance</u>	Not covered	Prior authorization may be required.
	<a href="#">Skilled nursing care</a>	20% <u>Coinsurance</u>	Not covered	Prior authorization may be required.
	<a href="#">Durable medical equipment</a>	20% <u>Coinsurance</u>	Not covered	Prior authorization may be required.
	<a href="#">Hospice services</a>	20% <u>Coinsurance</u>	Not covered	Prior authorization may be required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 Visit per year.
	Children's glasses	No charge	Not covered	1 Item per year.
	Children's dental check-up	Not covered	Not covered	-----None-----

### Excluded Services & Other Covered Services

Services your <a href="#">Plan</a> Generally Does NOT cover (Check your policy or <a href="#">plan</a> documentation for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>Dental care</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |  |  |   |   |
|--|--|---|---|
| • Bariatric surgery  | • Cosmetic Surgery (Correction of congenital deformities, or conditions from accidental injuries, scars, tumors, or disease) | • Hearing aids (two items per three years).               | • Private-duty nursing (On an outpatient basis) |
| • Chiropractic care (Limited to 25 specialists' visits per benefit period) |  | • Infertility treatment (See policy for coverage details) | • 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 [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: 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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-745-5507, TTY/TDD 1-844-517-3431.

—————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 prenatal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 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
<b>The total Peg would pay is</b>	<b>\$1,135</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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
<b>The total Joe would pay is</b>	<b>\$760</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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:

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

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



### Statement of Non-Discrimination

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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](mailto: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>.

