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/2020-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 deductible?	$3,350 individual / $6,700 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 services, primary care, specialist, and urgent care office visits, children's eye exam and glasses, generic and preferred brand 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 providers: $7,450 individual / $14,900 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 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 1-855-745-5507 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	-----None-----
	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 needed 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 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)	30% Coinsurance	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 drugs to treat your illness or condition More information about prescription drug coverage is available at Preferred Drug List.	Generic drugs (Tier 1)	Retail: $25 Copay / prescription; Mailorder: $62.50 Copay / prescription; deductible does not apply	Not covered	Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Preferred brand drugs (Tier 2)	Retail: $50 Copay / prescription; Mail order: $125 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Non-preferred brand drugs (Tier 3)	40% Coinsurance	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Specialty drugs (Tier 4)	40% Coinsurance	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	Not covered	Prior authorization may be required.
	Physician/surgeon fees	30% Coinsurance	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	Emergency room care	$600 Copay / visit with deductible	$600 Copay / visit with deductible	-----None-----
	Emergency medical transportation	30% Coinsurance	30% Coinsurance	-----None-----
	Urgent care	$60 Copay / visit; deductible does not apply	Not covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 Copay per day with deductible	Not covered	Prior authorization may be required.
	Physician/surgeon fees	No charge	Not covered	Prior authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay / office visit (deductible does not apply); 30% Coinsurance for all other outpatient services	Not covered	Prior authorization may be required. (PCP and other practitioner visits do not require prior authorization)
	Inpatient services	$750 Copay per day with deductible	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	$30 Copay / visit; deductible does not apply	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	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 facility services	$750 Copay per day with deductible	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).

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 may be required.
	Rehabilitation services	30% Coinsurance	Not covered	Prior authorization may be required. 60 Visits per year. 20 Visits per year per therapy (PT, OT, ST).
	Habilitation services	30% Coinsurance	Not covered	Prior authorization may be required.
	Skilled nursing care	30% Coinsurance	Not covered	Prior authorization may be required.
	Durable medical equipment	30% Coinsurance	Not covered	Prior authorization may be required.
	Hospice services	30% Coinsurance	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 Plan Generally Does NOT cover (Check your policy or plan documentation for more information and a list of any other excluded services.)

- 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.)

- Abortion
- Bariatric surgery
- Chiropractic care (Limited to 25 specialist visits per benefit period)
- Cosmetic surgery (Correction of congenital deformites, 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. 1-217-782-4515. 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. 1-217-782-4515. 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.

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Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 855-745-5507, TTY/TDD 866-565-8576

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-745-5507, TTY/TDD 866-565-8576

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 855-745-5507, TTY/TDD 866-565-8576

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-745-5507, TTY/TDD 866-565-8576

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	$3,350
Specialist copayment	$60
Hospital (Facility) copayment	$750
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	$3,350
Copayments	$1,400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,110**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	$3,350
Specialist copayment	$60
Hospital (Facility) copayment	$750
Other coinsurance	30%

This EXAMPLE even includes services like:
Primary care physician office visits *(including 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	$1,300
Copayments	$1,800
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,760**

Mia's Simple Fracture

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

The plan's overall deductible	$3,350
Specialist copayment	$60
Hospital (Facility) copayment	$750
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	$800
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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The plan 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 Insured by Celtic 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 1-855-745-5507 (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 (TTY/TDD 1-844-517-3431).
Gujarati:	□□ □□□□ □□□□ □□□ □□□□□ □□□ □□□ □□□□□ □□□ □□□□, from IlliniCare Health □□□□ □□□ □□□□□□ □□□ □□ □□□□, □□□ □□□□ □□□□ □□□□□ □□□□□□□ □□□ □□□ □□□□□□ □□□□□□□ □□□□□□ □□□□□□ □□. □□□□□□□□ □□□□ □□□ □□□□ □□□□ 1-855-745-5507 (TTY/TDD 1-844-517-3431) □□□ □□□ □□□.
Urdu:	اگر Ambetter from IlliniCare Healthکے بارے میں آپ، یا جن کی آپ مدد کررہے 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، 1-855-745-5507 (TTY/TDD 1-844-517-3431) پر کال 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, rufen Sie bitte die Nummer 1-855-745-5507 (TTY/TDD 1-844-517-3431) an.

Ambetter from IlliniCare Health is underwritten by Celtic Insurance Company.