
 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 ?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or \$5,650 individual / \$11,300 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 : \$6,950 individual / \$13,900 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			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	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	No charge	\$30 Copay / visit; deductible does not apply	Not covered	Cost sharing waived at non-IHCP with IHCP referral .
	Specialist visit	No charge	\$60 Copay / visit; deductible does not apply	Not covered	Cost sharing waived at non-IHCP with IHCP referral .
	Preventive care/screening/immunization	No charge	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. Cost sharing waived at non-IHCP with IHCP referral .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	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. Cost sharing waived at non-IHCP with IHCP referral .
	Imaging (CT/PET scans, MRIs)	No charge	20% Coinsurance	Not covered	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	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	Retail: \$10 Copay / prescription; Mail Order: \$25 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. Cost sharing waived at non-IHCP with IHCP referral .
	Preferred brand drugs (Tier 2)	No charge	Retail: \$55 Copay / prescription; Mail Order: \$137.50 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. Cost sharing waived at non-IHCP with IHCP referral .
	Non-preferred brand drugs (Tier 3)	No charge	30% 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. Cost sharing waived at non-IHCP with IHCP referral .
	Specialty drugs (Tier 4)	No charge	30% 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. Cost sharing waived at non-IHCP with IHCP referral .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% Coinsurance	Not covered	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
	Physician/surgeon fees	No charge	20% Coinsurance	Not covered	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
If you need immediate medical attention	Emergency room care	No charge	20% Coinsurance	20% Coinsurance	Cost sharing waived at non-IHCP with IHCP referral .

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*For more information about limitations and exceptions, see plan or policy document at <https://api.centene.com/EOC/2020/27833IL014.pdf>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	No charge	20% Coinsurance	20% Coinsurance	Cost sharing waived at non-IHCP with IHCP referral .
	Urgent care	No charge	\$60 Copay / visit; deductible does not apply	Not covered	Cost sharing waived at non-IHCP with IHCP referral .
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% Coinsurance	Not covered	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
	Physician/surgeon fees	No charge	20% Coinsurance	Not covered	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$30 Copay / office visit (deductible does not apply); 20% Coinsurance for all other outpatient services	Not covered	Prior authorization may be required. (PCP and other practitioner visits do not require prior authorization). Cost sharing waived at non-IHCP with IHCP referral .
	Inpatient services	No charge	20% Coinsurance	Not covered	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
If you are pregnant	Office visits	No charge	\$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). Cost sharing waived at non-IHCP with IHCP referral .
	Childbirth/delivery professional services	No charge	20% Coinsurance	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

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
					and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing waived at non-IHCP with IHCP referral .
	Childbirth/delivery facility services	No charge	20% Coinsurance	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). Cost sharing waived at non-IHCP with IHCP referral .
If you need help recovering or have other special health needs	Home health care	No charge	20% Coinsurance	Not covered	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
	Rehabilitation services	No charge	20% Coinsurance	Not covered	Prior authorization may be required. 60 visits per year. 20 visits per year per therapy (PT, OT, ST). Cost sharing waived at non-IHCP with IHCP referral .
	Habilitation services	No charge	20% Coinsurance	Not covered	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
	Skilled nursing care	No charge	20% Coinsurance	Not covered	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
	Durable medical equipment	No charge	20% Coinsurance	Not covered	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
	Hospice services	No charge	20% Coinsurance	Not covered	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	1 visit per year. Cost sharing waived at non-IHCP with IHCP referral .
	Children's glasses	No charge	No charge	Not covered	1 item per year. Cost sharing waived at non-IHCP with IHCP referral .
	Children's dental check-up	Not covered	Not covered	Not covered	-----None-----

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document 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 year)
- 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 [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 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, 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 pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$5,650
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$4,500
Copayments	\$400
Coinsurance	\$2,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,960

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$5,650
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$1,400
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$3,360

Mia's Simple Fracture

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

■ The plan's overall deductible	\$5,650
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,300
Copayments	\$200
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.

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>.



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