



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 <a href="#">deductible</a> ?                                | \$200 individual / \$400 family.                                                                                                                                                                                                                                           | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care services</a> , primary care, <a href="#">specialist</a> , and <a href="#">urgent care</a> office visits, children's eye exam and glasses, generic and preferred brand drugs are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                                        | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> : \$750 individual / \$1,500 family. No, for <a href="#">non-network providers</a> .                                                                                                                                                 | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> and health care this <a href="#">plan</a> doesn't cover.                                                                                                                                                                                          | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="#">Find a Provider</a> or call 1-855-745-5507 for a list of <a href="#">network providers</a> .                                                                                                                                                          | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                                                                                                                        | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



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 <a href="#">Provider</a><br>(You will pay the least)                 | Out-of-Network <a href="#">Provider</a><br>(You will pay the most) |                                                                                                                                                                                                     |
| If you visit a health care <a href="#">provider's office</a> or clinic | Primary care visit to treat an injury or illness                           | No charge                                                                    | Not covered                                                        | ----None----                                                                                                                                                                                        |
|                                                                        | <a href="#">Specialist</a> visit                                           | \$5 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply | 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)                        | 30% <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)                                               | 30% <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<br>(You will pay the least)                                                                                | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                           |
| <b>If you need drugs to treat your illness or condition</b><br>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 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <u>cost-sharing</u> amount.                                      |
|                                                                                                                                                                                        | Preferred brand drugs (Tier 2)                 | Retail: \$25 <u>Copay</u> / prescription; Mail order: \$62.50 <u>Copay</u> / prescription; <u>deductible</u> does not apply | Not covered                                        | Prior authorization may be required. <u>Prescription drugs</u> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <u>cost-sharing</u> amount. |
|                                                                                                                                                                                        | Non-preferred brand drugs (Tier 3)             | 40% <u>Coinsurance</u>                                                                                                      | Not covered                                        | Prior authorization may be required. <u>Prescription drugs</u> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <u>cost-sharing</u> amount. |
|                                                                                                                                                                                        | <a href="#">Specialty drugs</a> (Tier 4)       | 40% <u>Coinsurance</u>                                                                                                      | Not covered                                        | Prior authorization may be required. <u>Prescription drugs</u> are provided up to 30 days retail and up to 30 days through mail order.                                                                    |
| <b>If you have outpatient surgery</b>                                                                                                                                                  | Facility fee (e.g., ambulatory surgery center) | 30% <u>Coinsurance</u>                                                                                                      | Not covered                                        | Prior authorization may be required.                                                                                                                                                                      |
|                                                                                                                                                                                        | Physician/surgeon fees                         | 30% <u>Coinsurance</u>                                                                                                      | Not covered                                        | Prior authorization may be required.                                                                                                                                                                      |

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\*For more information about limitations and exceptions, see plan or policy document at <https://api.centene.com/EOC/2020/27833IL015.pdf>

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                  |                                                    | Limitation, Exceptions, & Other Important Information                                                       |
|---------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)                                       | Out-of-Network Provider<br>(You will pay the most) |                                                                                                             |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$75 <u>Copay</u> / visit with <u>deductible</u>                                   | \$75 <u>Copay</u> / visit with <u>deductible</u>   | ----None----                                                                                                |
|                                                                           | <a href="#">Emergency medical transportation</a> | 30% <u>Coinsurance</u>                                                             | 30% <u>Coinsurance</u>                             | ----None----                                                                                                |
|                                                                           | <a href="#">Urgent care</a>                      | \$10 <u>Copay</u> / visit; <u>deductible</u> does not apply                        | Not covered                                        | ----None----                                                                                                |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | \$75 <u>Copay</u> per day with <u>deductible</u>                                   | 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                              | No charge / office visit; 30% <u>Coinsurance</u> for all other outpatient services | Not covered                                        | Prior authorization may be required. (PCP and other practitioner visits do not require prior authorization) |
|                                                                           | Inpatient services                               | \$75 <u>Copay</u> per day with <u>deductible</u>                                   | Not covered                                        | Prior authorization may be required.                                                                        |

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| Common Medical Event | Services You May Need                     | What You Will Pay                                |                                                    | Limitation, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                      |
|----------------------|-------------------------------------------|--------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                      |                                           | Network Provider<br>(You will pay the least)     | Out-of-Network Provider<br>(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 | 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 facility services     | \$75 <u>Copay</u> per day with <u>deductible</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). |

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| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                   |                                                           | Limitation, Exceptions, & Other Important Information                                                 |
|----------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network <u>Provider</u><br>(You will pay the least) | Out-of-Network <u>Provider</u><br>(You will pay the most) |                                                                                                       |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 30% <u>Coinsurance</u>                              | Not covered                                               | Prior authorization may be required.                                                                  |
|                                                                | <a href="#">Rehabilitation services</a>   | 30% <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>     | 30% <u>Coinsurance</u>                              | Not covered                                               | Prior authorization may be required.                                                                  |
|                                                                | <a href="#">Skilled nursing care</a>      | 30% <u>Coinsurance</u>                              | Not covered                                               | Prior authorization may be required.                                                                  |
|                                                                | <a href="#">Durable medical equipment</a> | 30% <u>Coinsurance</u>                              | Not covered                                               | Prior authorization may be required.                                                                  |
|                                                                | <a href="#">Hospice services</a>          | 30% <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-----                                                                                        |

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<https://api.centene.com/EOC/2020/27833IL015.pdf>

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> .) |                  |                                                      |                        |
| • Acupuncture                                                                                                                                                                                          | • Long-term care | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

|                                                                                                                                              |                                                                                                                              |                                                           |                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------|
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |                                                                                                                              |                                                           |                                                                                |
| • Abortion                                                                                                                                   | • Cosmetic surgery (Correction of congenital deformities, or conditions from accidental injuries, scars, tumors, or disease) | • Infertility treatment (See policy for coverage details) | • Routine eye care (Adult-one visit & one item per year. Dollar limits apply.) |
| • Bariatric surgery                                                                                                                          | • Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year.)                              | • Private-duty nursing (On an outpatient basis)           | • Routine foot care (For diabetes treatment)                                   |
| • Chiropractic care (Limited to 25 <a href="#">specialist</a> visits per benefit period)                                                     | • Hearing aids (Two items per three years)                                                                                   |                                                           |                                                                                |

**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](#).

### 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 a'ohwol ninisingo, kwijigo holne' 855-745-5507, TTY/TDD 866-565-8576

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$200 |
| <a href="#">Specialist copayment</a>                          | \$5   |
| Hospital (Facility) <a href="#">copayment</a>                 | \$75  |
| Other <a href="#">coinsurance</a>                             | 30%   |
| <b>This EXAMPLE even includes services like:</b>              |       |
| Specialist office visits ( <i>prenatal care</i> )             |       |
| Childbirth/Delivery Professional Services                     |       |
| Childbirth/Delivery Facility Services                         |       |
| Diagnostic test ( <i>ultrasounds and blood work</i> )         |       |
| Specialist visit ( <i>anesthesia</i> )                        |       |

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$200        |
| Copayments                        | \$80         |
| Coinsurance                       | \$300        |
| What isn't covered                |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$640</b> |

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

|                                                                             |       |
|-----------------------------------------------------------------------------|-------|
| The <a href="#">plan's</a> overall <a href="#">deductible</a>               | \$200 |
| <a href="#">Specialist copayment</a>                                        | \$5   |
| Hospital (Facility) <a href="#">copayment</a>                               | \$75  |
| Other <a href="#">coinsurance</a>                                           | 30%   |
| <b>This EXAMPLE even includes services like:</b>                            |       |
| Primary care physician office visits ( <i>including disease education</i> ) |       |
| Diagnostic tests ( <i>blood work</i> )                                      |       |
| Prescription drugs                                                          |       |
| Durable medical equipment ( <i>glucose meter</i> )                          |       |

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$200        |
| Copayments                        | \$200        |
| Coinsurance                       | \$300        |
| 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$200 |
| <a href="#">Specialist copayment</a>                          | \$5   |
| Hospital (Facility) <a href="#">copayment</a>                 | \$75  |
| Other <a href="#">coinsurance</a>                             | 30%   |
| <b>This EXAMPLE even includes services like:</b>              |       |
| Emergency room care ( <i>including medical supplies</i> )     |       |
| Diagnostic test ( <i>x-ray</i> )                              |       |
| Durable medical equipment ( <i>crutches</i> )                 |       |
| Rehabilitation services ( <i>physical therapy</i> )           |       |

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$200        |
| Copayments                        | \$20         |
| Coinsurance                       | \$300        |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$520</b> |

### 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](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>.

|                    |                                                                                                                                                                                                                                                                                                                            |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Spanish:</b>    | 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).                                                          |
| <b>Polish:</b>     | 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).                                                         |
| <b>Chinese:</b>    | 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)。                                                                                                                                                                                      |
| <b>Korean:</b>     | 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.                                                                                                                              |
| <b>Tagalog:</b>    | Kung ikaw, o ang iyong tinutulungan, 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).                                     |
| <b>Arabic:</b>     | إذا كان لديك أو لدى شخص تساعد 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).                                                                                                     |
| <b>Russian:</b>    | 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). |
| <b>Gujarati:</b>   | મારું કોઈપણ પ્રશ્ન અથવા કોઈપણ વ્યક્તિને મદદ કરવામાં આવતી વખતે, અમને Ambetter from IlliniCare Health ના કોઈપણ પ્રશ્ન અથવા માહિતીની જરૂર હોય તો, અમે તમને મફત સહાય અને માહિતી તમારા માન્ય ભાષામાં આપી શકીએ છીએ. 1-855-745-5507 (TTY/TDD 1-844-517-3431) પર કોલ કરો.                                                          |
| <b>Urdu:</b>       | اگر Ambetter from IlliniCare Health کے بارے میں آپ، یا جن کی آپ مدد کر رہے ہیں ان کے سوالات ہوں تو، آپ کو بلا معاوضہ 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۔                                                                  |
| <b>Vietnamese:</b> | 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).                                                    |
| <b>Italian:</b>    | 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 il 1-855-745-5507 (TTY/TDD 1-844-517-3431).                                                       |
| <b>Hindi:</b>      | 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 दुभाषिणे से बात करने के लिए 1-855-745-5507 (TTY/TDD 1-844-517-3431) पर कॉल करें।                                                      |
| <b>French:</b>     | 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).                                      |
| <b>Greek:</b>      | 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).                                                     |
| <b>German:</b>     | 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.                                   |