Ambetter from MHS: Ambetter Balanced Care 28 (2021) + Vision + Adult Dental

Coverage for: Individual/Family| Plan Type: EPO

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.mhsindiana.com/2021-brochures.html, or call 1-877-687-1182 (TTY/TDD 1-800-743-3333). 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 1-877-687-1182 (TTY/TDD 1-800-743-3333) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your cost for services this plan covers.
Are there services covered before you meet your deductible?	Yes, except for Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty drugs (Tier 4).	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?	Yes, $1,500 individual / $3,000 family for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers: $8,200 individual / $16,400 family. Not applicable for out-of-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, balance-billing charges, 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 1-877-687-1182 (TTY/TDD 1-800-743-3333) 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
		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	$50 Copay / visit	Not covered	Virtual Visits from Ambetter Health covered at $0, providers covered in full.
	Specialist visit	$90 Copay / visit	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)	$50 Copay / test for laboratory outpatient & professional services; 50% Coinsurance for x-ray and diagnostic imaging	Not covered	Prior authorization may be required. Covered no limit. 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)	50% Coinsurance	Not covered	Prior authorization may be required. Covered no limit.
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: $30 Copay / prescription	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% Coinsurance; subject to Rx drug deductible	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. $1,500 individual / $3,000 family Rx drug deductible for preferred brand, non-preferred brand, and specialty drugs.
	Non-preferred brand drugs (Tier 3)	Retail: 50% Coinsurance; subject to Rx drug deductible	Not covered	
	Specialty drugs (Tier 4)	Retail: 50% Coinsurance; subject to Rx drug deductible	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. $1,500 individual / $3,000 family Rx drug deductible for preferred brand, non-preferred brand, and specialty drugs.

*For more information about limitations and exceptions, see plan or policy document at https://api.centene.com/EOC/2021/76179IN013.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	Not covered	Prior authorization may be required. Covered no limit.
	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered no limit.
If you need immediate medical attention	Emergency room care	50% Coinsurance	50% Coinsurance; deductible does not apply	The provider may be able to balance bill you for services received out-of-network.
	Emergency medical transportation	50% Coinsurance	50% Coinsurance; deductible does not apply	The provider may be able to balance bill you for services received out-of-network.
	Urgent care	$60 Copay / visit	Not covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	50% Coinsurance	Not covered	Prior authorization may be required. Covered no limit.
	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered no limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 Copay / Office Visit; 50% Coinsurance for all other outpatient services	Not covered	Prior authorization may be required. Covered no limit. (PCP and other practitioner visits do not require prior authorization).
	Inpatient services	50% Coinsurance	Not covered	Prior authorization may be required. Covered no limit.
If you are pregnant	Office visits	$50 Copay / visit	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, such as routine pre-natal and post-natal screenings. 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	50% Coinsurance	Not covered	Prior authorization may be required. Cost-sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services
	Childbirth/delivery facility services	50% Coinsurance	Not covered	

*For more information about limitations and exceptions, see plan or policy document at https://api.centene.com/EOC/2021/76179IN013.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 100 visits per year.
	Rehabilitation services	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 60 combined visits per year (20 visits each for outpatient physical, speech and occupational therapy); limited to 36 visits per year for cardiac rehabilitation; limited to 20 visits per year for pulmonary rehabilitation.
	Habilitation services	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 60 combined visits per year (20 visits each for outpatient physical, speech and occupational therapy).
	Skilled nursing care	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 90 days per year.
	Durable medical equipment	50% Coinsurance	Not covered	Prior authorization may be required. Covered no limit.
	Hospice services	50% Coinsurance	Not covered	Prior authorization may be required. Covered no limit.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge	Not covered	Limited to 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 document for more information and a list of any other excluded services.)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

*For more information about limitations and exceptions, see plan or policy document at https://api.centene.com/EOC/2021/76179IN013.pdf.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care (Limited to 12 visits per year) • Dental care (Adult-visit & item limits apply per year. $1,000 annual dollar limit per year.)	• Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility. Services to treat the underlying medical conditions that cause infertility are covered (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).)	• Private-duty nursing (On an outpatient basis – limited to 82 visits per year) • Routine eye care (Adult-visit & one item per year. Dollar limits apply.) • Routine foot care (Related to 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 MHS at 1-877-687-1182 (TTY/TDD 1-800-743-3333); Indiana Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, IN, 46204, Phone No. 1-317 232-2385 or 1-800 622-4461. 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: Indiana Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, IN, 46204, Phone No. 1-317 232-2385 or 1-800 622-4461.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-687-1182 (TTY/TDD 1-800-743-3333).

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 $0
- Specialist copayment $90
- Hospital (facility) coinsurance 50%
- Other coinsurance 50%

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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$4,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,060

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

- The plan's overall deductible $0
- Specialist copayment $90
- Hospital (facility) coinsurance 50%
- Other coinsurance 50%

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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,120

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible $0
- Specialist copayment $90
- Hospital (facility) coinsurance 50%
- Other coinsurance 50%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,500

The plan would be responsible for the other costs of these EXAMPLE covered services.

Statement of Non-Discrimination

Ambetter from MHS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from MHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from MHS:

- 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 MHS at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

If you believe that Ambetter from MHS 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 MHS, Grievance & Appeals Department, PO Box 441567, Indianapolis, IN 46244, 1-877-687-1182 (TTY/TDD 1-800-743-3333), Fax 1-866-714-7993. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from MHS 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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Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de MHS, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from MHS 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 1-877-687-1182 (TTY/TDD 1-800-743-3333)。
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from MHS 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 1-877-687-1182 (TTY/TDD 1-800-743-3333) an.
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from MHS, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kawl 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Burmese:	သင် သို့မဟုတ် သင်မှကူညီနေသူတစ်ဦးဦးတွင် Ambetter from MHS အကြောင်း မေးစရာများရှိပါက အခမဲ့အကူအညီ ရယူပိုင်ခွင့်နှင့် သင်၏ဘာသာ စကားဖြင့် အချက်အလက်များကို အခမဲ့ရယူပိုင်ခွင့် ရှိပါသည်။ စကားပြန်တစ်ဦးနှင့် စကားပြောဆိုရန် 1-877-687-1182 (TTY/TDD 1-800-743-3333) ကို ဖုန်းဆက်ပါ။
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from MHS، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from MHS 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1182(TTY/TDD 1-800-743-3333)로 전화하십시오.
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from MHS, 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 1-877-687-1182 (TTY/TDD 1-800-743-3333).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from MHS, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Japanese:	Ambetter from MHS について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1182 (TTY/TDD 1-800-743-3333) までお電話ください。
Dutch:	Als u of iemand die u helpt vragen heeft over Ambetter from MHS, hebt u recht op gratis hulp en informatie in uw taal. Bel 1-877 687-1182 (TTY/TDD (teksttelefoon) 1-800 743-3333) om met een tolk te spreken.
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from MHS, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from MHS вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Punjabi:	ਜੇ ਤੁਹਾਡੇ, ਜਾਂ ਤੁਹਾਡੀ ਮਦਦ ਲੈ ਰਹੇ ਕਿਸੇ ਵਿਅਕਤੀ ਦੇ ਮਨ ਵਿਚ Ambetter from MHS ਦੇ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮੁਫਤ ਮਦਦ ਲੈਣ ਦਾ ਪੂਰਾ ਹੱਕ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 1-877-687-1182 (TTY/TDD 1-800-743-3333) 'ਤੇ ਕਾਲ ਕਰੋ।
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from MHS 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 1-877-687-1182 (TTY/TDD 1-800-743-3333) पर कॉल करें।

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