




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, contact www.caresource.com/marketplace or call 1-833-230-2030. 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 www.caresource.com/marketplace or call 1-833-230-2030 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$900 individual/\$1,800 family per benefit year	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 .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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 ?	\$1,900 individual/ \$3,800 family	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 www.caresource.com/marketplace or call 1-833-230-2030 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	\$5 copay	Not covered	None
	Specialist visit	\$30 copay	Not covered	Plan covers 100% of allowed amount in excess of the copayment . Copayment waived when the only charge is for allergy injections/serum. If you receive services in addition to office visits, additional copayments , deductibles , or coinsurance may apply.
	Other practitioner office visit Nurse practitioner/retail clinic	\$5 copay	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)	X-ray: \$125 copay after deductible Lab: 10% coinsurance after deductible	Not covered	May require prior authorization May require prior authorization
	Imaging (CT/PET scans, MRIs)	\$175 copay after deductible	Not covered	Prior authorization required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caresource.com/marketplace .	Preventive drugs	Retail: No charge Mail-Order: No charge	Not covered	Retail: Up to a 30-day supply
	Low cost drugs	Retail: \$15 copay Mail-Order: \$37.50 copay	Not covered	Mail-Order: Up to a 90-day supply for Preventive, Low Cost, and Brand drugs/Up to a 30-day supply for Specialty drugs
	Preferred brand drugs	Retail: \$35 copay Mail-Order: \$87.50 copay	Not covered	Certain drugs may require a prior authorization.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.caresource.com/marketplace or call 1-833-230-2030.

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)	
	Non-preferred brand drugs	Retail: 10% coinsurance after deductible Mail-Order: 10% coinsurance after deductible	Not covered	Retail: Up to a 30-day supply
	Specialty drugs preferred	Retail: 10% coinsurance after deductible Mail-Order: 10% coinsurance after deductible	Not covered	Mail-Order: Up to a 90-day supply for Preventive, Low Cost, and Brand drugs/Up to a 30-day supply for Specialty drugs
	Specialty drugs non-preferred	Retail: 50% coinsurance after deductible Mail-Order: 50% coinsurance after deductible	Not covered	Certain drugs may require a prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	May require prior authorization
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	May require prior authorization
If you need immediate medical attention	Emergency room care	\$200 copay after deductible	\$200 copay after deductible	<u>Copayment</u> waived if you are admitted to the hospital directly from the Emergency Department.
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	Prior authorization is not required for emergency ambulance transportation or for facility to facility transfers. All other ambulance transportation requires prior authorization.
	Urgent care	\$75 copay	\$75 copay	If you receive services in addition to <u>urgent care</u> , additional <u>copayments</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 copay after deductible	Not covered	Prior authorization required
	Physician/surgeon fees	\$200 copay after deductible	Not covered	Prior authorization required

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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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 copay for office visits and 10% coinsurance after deductible for other outpatient services	Not covered	Prior authorization is required for all inpatient stays and residential treatment programs. Partial hospitalization programs and intensive outpatient services may require prior authorization.
	Inpatient services	\$200 copay after deductible	Not covered	
If you are pregnant	Office visits	\$30 copay	Not covered	<p><u>Copayment</u> covers initial physician visit and all subsequent prenatal visits, postnatal visits, and physician delivery charges covered under the Global Maternity Fee. Additional <u>copayments</u>, <u>deductibles</u>, or <u>coinsurance</u> may apply depending on services rendered in addition to the Global Maternity Fee.</p> <p>Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u>, or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</p> <p>Your cost for inpatient services only. See above for physician delivery charges.</p>
	Childbirth/delivery professional services	\$200 copay after deductible	Not covered	
	Childbirth/delivery facility services	\$200 copay after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	Not covered	Prior authorization required 120 combined visits per benefit year. A visit equals at least 4 hours.
	Rehabilitation services			40 combined visits per benefit year
	Physical therapy	\$5 copay	Not covered	
	Occupational therapy	\$5 copay		
	Speech therapy	10% coinsurance after deductible		
	Audiology	10% coinsurance after deductible		
Cognitive rehabilitation	10% coinsurance after deductible			
Spinal manipulation	10% coinsurance after deductible			

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.caresource.com/marketplace or call 1-833-230-2030.

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)	
	<u>Habilitation services</u>			
	Physical therapy	\$5 copay	Not covered	40 combined visits per benefit year
	Occupational therapy	\$5 copay		
	Speech therapy	10% coinsurance after deductible		
Audiology	10% coinsurance after deductible			
	Spinal manipulation	10% coinsurance after deductible		
	<u>Skilled nursing care</u>	\$200 copay after deductible	Not covered	Prior authorization required 60 day limit per benefit year
	<u>Durable medical equipment</u>	10% coinsurance after deductible	Not covered	May require prior authorization
	<u>Hospice services</u>	10% coinsurance after deductible	Not covered	Prior authorization is required for inpatient, respite, or continuous care levels of care.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam per benefit year
	Low vision testing and aids	No charge	Not covered	Limited to one evaluation and aid per benefit year.
	Children's eyewear	No charge	Not covered	Limited to one pair of glasses or contact lenses once per benefit year. If medically necessary, a replacement pair of glasses is allowed.
	Children's dental check-up	\$10 copay	Not covered	2 dental check-ups per benefit year

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.caresource.com/marketplace or call 1-833-230-2030.

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
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care

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

- Cosmetic surgery
- Weight loss programs

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: 1-800-656-2298. 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 the Georgia Department of Insurance: 1-800-656-2298.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-230-2030.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-230-2030.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-230-2030.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-230-2030.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

■ The plan's overall deductible	\$900
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$200
■ Other coinsurance	10%

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	\$12,840
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$395
Coinsurance	\$328
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,683

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$900
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$200
■ Other coinsurance	10%

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	\$7,460
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$842
Coinsurance	\$158
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,955

Mia's Simple Fracture

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

■ The plan's overall deductible	\$900
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$200
■ Other coinsurance	10%

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	\$2,010
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$235
Coinsurance	\$139
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,274

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

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please contact CareSource at 1-855-202-0729 TTY:711.

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.