**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 1-888-815-6446. 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 1-888-815-6446 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $5,700 individual/$11,400 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?** | $7,700 individual/<br>$15,400 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 1-888-815-6446 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 | $15 copay | Not covered | None |
| | Specialist visit | $40 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<br>Nurse practitioner/retail clinic<br>Chiropractor | $15 copay<br>20% coinsurance after deductible | Not covered | None<br>Manipulation therapy - 20 visits per benefit year |
| | 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: $150 copay after deductible<br>Lab: 20% coinsurance after deductible | Not covered | May require prior authorization<br><br>May require prior authorization |
| | Imaging (CT/PET scans, MRIs) | $250 copay after deductible | Not covered | May require prior authorization |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.caresouce.com/ marketplace. | Preventive drugs | Retail: No charge<br>Mail-Order: No charge | Not covered | Retail: Up to a 30-day supply<br>Mail-Order: Up to a 90-day supply<br><br>Certain drugs may require a prior authorization.<br><br>You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. |
| | Generic drugs | Retail: $15 copay<br>Mail-Order: $37.50 copay | Not covered | |
| | Preferred brand drugs | Retail: $45 copay<br>Mail-Order: $112.50 copay | Not covered | |

* For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 1-888-815-6446.

| 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: 20% coinsurance after deductible<br>Mail-Order: 20% coinsurance after deductible | Not covered | Retail: Up to a 30-day supply<br>Mail-Order: Up to a 90-day supply<br><br>Certain drugs may require a prior authorization.<br><br>You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. |
| | Specialty drugs | Retail: 20% coinsurance after deductible<br>Mail-Order: 20% coinsurance after deductible | Not covered | |
| | Specialty drugs non-preferred | Retail: 50% coinsurance after deductible<br>Mail-Order: 50% coinsurance after deductible | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | Not covered | May require prior authorization |
| | Physician/surgeon fees | 20% coinsurance after deductible | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | $500 copay after deductible | $500 copay after deductible | Copayment waived if you are admitted to the hospital directly from the Emergency Department. |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | Ambulance transports must be made to the closest local facility that can provide you with covered services appropriate for your medical condition. |
| | Urgent care | $75 copay | $75 copay | If you receive services in addition to urgent care, additional copayments, deductibles, or coinsurance may apply. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 copay after deductible | Not covered | Prior authorization required |
| | Physician/surgeon fees | $500 copay after deductible | Not covered | None |

| 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 | $15 copay for office visits and 20% 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 | $500 copay after deductible | Not covered | |
| **If you are pregnant** | Office visits | $40 copay | Not covered | Copayment covers initial physician visit and all subsequent prenatal visits, postnatal visits, and physician delivery charges covered under the Global Maternity Fee. Additional copayments, deductibles, or coinsurance may apply depending on services rendered in addition to the Global Maternity Fee.<br><br>Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | $500 copay after deductible | Not covered | |
| | Childbirth/delivery facility services | $500 copay after deductible | Not covered | Your cost for inpatient services only. See above for physician delivery charges. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance after deductible | Not covered | 100 combined visits per benefit year. A visit equals at least 4 hours. |
| | Rehabilitation services | | Not covered | |
| | Physical therapy | $15 copay | | 25 visits per benefit year |
| | Occupational therapy | $15 copay | | 25 visits per benefit year |
| | Speech therapy | 20% coinsurance after deductible | | 25 visits per benefit year |
| | Pulmonary rehabilitation | 20% coinsurance after deductible | | 25 visits per benefit year |
| | Cardiac rehabilitation | 20% coinsurance after deductible | | 36 visits per benefit year |
| | Chiropractic services | 20% coinsurance after deductible | | Manipulation therapy - 20 visits per benefit year |

| 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) | |
| | Post-cochlear implant aural therapy<br>Cognitive rehabilitation therapy | 20% coinsurance after deductible<br>20% coinsurance after deductible | Not covered | 30 visits per benefit year<br>20 visits per benefit year |
| | Habilitation services<br>Physical therapy<br>Occupational therapy<br>Speech therapy | <br>$15 copay<br>$15 copay<br>20% coinsurance after deductible | Not covered | <br>25 visits per benefit year<br>25 visits per benefit year<br>25 visits per benefit year |
| | Skilled nursing care | $400 copay after deductible | Not covered | Any combination of benefits for skilled nursing facility/inpatient rehabilitation services is limited to 90 days per calendar year. |
| | Private duty nursing | 20% coinsurance after deductible | Not covered | 250 visits per benefit year. A visit equals 8 hours. |
| | Durable medical equipment | 20% coinsurance after deductible | Not covered | May require prior authorization |
| | Hospice services | No charge | No charge | 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 exam | 20% coinsurance after deductible | Not covered | May require prior authorization |
| | Children's glasses | No charge | Not covered | Limited to one pair of glasses or a 12-month supply of contact lenses per benefit year. If medically necessary, a replacement pair of glasses is allowed. |
| | Children's dental check-up | No charge | Not covered | 2 dental check-ups per benefit year |

## 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 when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Dental care (Adult), if optional Dental + Vision is selected:
  - No charge for preventive services
  - 25% coinsurance for basic and major restorative services
  - $800 limit per benefit year
- Hearing aids
- Private duty nursing
- Routine eye care (Adult)
- If optional Dental + Vision is selected:
  - $250 limit per benefit year for glasses or contacts

**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: 1-800-595-6053. 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 Kentucky Department of Insurance: 1-800-595-6053.

**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 1-888-815-6446.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-815-6446.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-815-6446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-815-6446.

*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 | $5,700 |
| Specialist copayment | $40 |
| Hospital (facility) copayment | $500 |
| 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** | **$12,840** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,700 |
| Copayments | $740 |
| Coinsurance | $655 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,155** |

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

| | |
|---|---|
| The plan's overall deductible | $5,700 |
| Specialist copayment | $40 |
| Hospital (facility) copayment | $500 |
| 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** | **$7,460** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,489 |
| Copayments | $1,250 |
| Coinsurance | $372 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$3,167** |

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

| | |
|---|---|
| The plan's overall deductible | $5,700 |
| Specialist copayment | $40 |
| Hospital (facility) copayment | $500 |
| 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** | **$2,010** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,109 |
| Copayments | $330 |
| Coinsurance | $277 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,716** |

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

CareSource

**This Notice has Important Information.** This notice has important information about your application or coverage through CareSource. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-888-815-6446 TTY:711.

**ARABIC**
يحتوي هذا الإشعار على معلومات مهمة. يحتوي هذا الإشعار على معلومات مهمة بخصوص طلبك أو التغطية التي تحصل عليها من خلال CareSource. ابحث عن التواريخ المهمة في هذا الإشعار. قد تحتاج إلى اتخاذ إجراء معين قبل حلول أحد التواريخ للحفاظ على التغطية الصحية التي تحصل عليها أو للحصول على مساعدة بشأن التكاليف. يحق لك الحصول على مساعدة ومعلومات مجانا وباللغة التي تتحدث بها. اتصل على 1-888-815-6446 TTY:711.

**AMHARIC** ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ CareSource ሽፋን አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤናን ሽፋንዎን ለመጠበቅ በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። 1-888-815-6446 TTY:711 ይደውሉ።

**BURMESE** ဤအသိပေးစာတွင် အရေးကြီးသော အချက်အလက်များ ပါဝင်ပါသည်။ ဤအသိပေးစာတွင် သင့်လျှောက်ထားမှု သို့မဟုတ် CareSource အတွင်း အကျုံးဝင်မှုအကြောင်း အရေးကြီးသော အချက်အလက်များ ပါဝင်ပါသည်။ ဤအသိပေးစာတွင်း အရေးကြီးသော ရက်စွဲများကို ရှာထားပါ။ သင့်ကျန်းမာရေး အကျုံးဝင်မှုအား ဆက်လက်ထားရှိထားရန် သို့မဟုတ် ကုန်ကျစရိတ်များနှင့် ပတ်သက်ပြီး အကူအညီရရှိရန် အချို့သော နောက်ဆုံးရက် သတ်မှတ်ချက်များဖြင့် ဆောင်ရွက်မှုပြုရန် လိုအပ်နိုင်ပါသည်။ သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ 1-888-815-6446 TTY:711 ဤတွင် နံပါတ်ဖြည့်သွင်းပါ] သို့ ခေါ်ဆိုပါ။

**CHINESE** 此通知包含重要信息。 此通知包含关于您的申请以及 CareSource 医疗保险覆盖范围的重要信息。 请仔细查看本通知中的关键日期。 您可能需要在某些标注的截止日期前采取行动，以确保您的健康保险有效或者付费项目获得帮助。您有权免费获得以您的语言提供的此信息和帮助。 请致电 1-888-815-6446 TTY:711。

**CUSHITE – OROMO** Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa CareSource tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa1-888-815-6446 TTY:711 tii bilbilaa.

**DUTCH** Deze kennisgeving bevat belangrijke informatie. Deze kennisgeving bevat belangrijke informatie over uw aanvraag of dekking via CareSource. Let op belangrijke data in deze kennisgeving. Het kan nodig zijn om actie te ondernemen vóór bepaalde deadlines om uw gezondheidszorgdekking of hulp met de kosten te behouden. U hebt het recht om deze informatie en hulp kosteloos te ontvangen in uw taal. Bel 1-888-815-6446 TTY:711.

**FRENCH (CANADA)** Cet avis contient des renseignements importants. Cet avis contient des renseignements importants sur votre demande d'assurance auprès de CareSource ou la couverture obtenue par l'intermédiaire de CareSource. Prenez connaissance des dates clés mentionnées dans le présent avis. Assurez-vous de respecter les délais indiqués pour conserver votre protection et contribuer à réduire les coûts. Vous avez le droit d'obtenir gratuitement ces renseignements et du soutien dans votre langue. Téléphonez au 1-888-815-6446 TTY:711.

**GERMAN** Dieser Hinweis enthält wichtige Information. Dieser Hinweis enthält wichtige Information über Ihren Antrag oder Ihren Schutz durch CareSource. Achten Sie auf Schlüsseltermine in diesem Hinweis. Sie müssen eventuell innerhalb von bestimmten Fristen Maßnahmen ergreifen, um Ihre Gesundheitsversorgung aufrecht zu erhalten oder Hilfe mit den Kosten zu bekommen. Sie haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache diese Hilfe und Information zu bekommen. Rufen Sie die Nummer 1-888-815-6446 TTY:711an.

**GUJARATI** આ સૂર્ન મ i અગત્ની મ હહતી છે. આ સૂર્ન મ i તમ રી અરજી અથિ CareSource દ્વ ર સાંકળ ની અગત્ની મ હહતી છે. આ સૂર્ન મ i ની ખ સ ત રીખો જ ઓ. તમે તમારા આરોગ્ય કવરેજ રાખવા અથવા ખર્ચ સાથે મદદ કરવા માટે અમુક રોક્કસ મુદતો દ્વારા પગલાાં લેવાની જરૂર છે. તમને આ મ હહતી અને મદદ તમ રી ભ ષ મ i વિને મૂલ્ય મેળિ ની અવિક ર છે. આ 1-888-815-6446 TTY:711સાંપકય કરો.

**HINDI** इस नोटिस में महत्वपूर्ण सूचना है। इस नोटिस में आपके आवेदन या CareSource के माध्यम से आपके कवरेज के बारे में महत्वपूर्ण जानकारी है। इस नोटिस में मुख्य तारिखों को देखें। आपको लागत सहित अपने हेल्थ कवरेज या सहायता को बनाए रखने के लिए विभिन्न समयसीमाओं में कार्रवाई करने की जरूरत हो सकती है। आपके पास बग़ैर किसी लागत के अपनी भाषा में यह जानकारी और सहायता प्राप्त करने का अधिकार है। कॉल करें, 1-888-815-6446 TTY:711.

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**RUSSIAN** Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком, позвоните по номеру 1-888-815-6446 TTY:711.

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**VIETNAMESE** Thông báo này có thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin hoặc bảo hiểm của bạn thông qua CareSource. Hãy xem những ngày quan trọng trong thông báo này. Bạn có thể cần phải hành động trước một số thời hạn nhất định để duy trì bảo hiểm sức khỏe của mình hay được trợ giúp có trả phí. Bạn có quyền được nhận thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Vui lòng gọi số 1-888-815-6446 TTY:711.

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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 1-888-815-6446 TTY:711.

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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.