




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](http://www.caresource.com/marketplace) or call 1-855-202-0622. 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](http://www.caresource.com/marketplace) or call 1-855-202-0622 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$5,300 individual/\$10,600 family per benefit year	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</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.
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> ?	\$6,750 individual/ \$13,500 family	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> , <a href="#">balance-billing</a> charges 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="http://www.caresource.com/marketplace">www.caresource.com/marketplace</a> or call 1-855-202-0622 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		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	50% coinsurance after deductible	Not covered	None
	<a href="#">Specialist</a> visit	50% coinsurance after deductible	Not covered	<a href="#">Plan</a> covers 100% of <a href="#">allowed amount</a> in excess of the <a href="#">copayment</a> . <a href="#">Copayment</a> waived when the only charge is for allergy injections/serum. If you receive services in addition to office visits, additional <a href="#">copayments</a> , <a href="#">deductibles</a> , or <a href="#">coinsurance</a> may apply.
	Other practitioner office visit Nurse practitioner/retail clinic	50% coinsurance after deductible	Not covered	None
	Chiropractor	50% coinsurance after deductible	Not covered	Manipulation therapy - 30 visits per benefit year**
	<a href="#">Preventive care/screening/immunization</a>	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: 50% coinsurance after deductible Lab: 50% coinsurance after deductible	Not covered	May require prior authorization May require prior authorization
	Imaging (CT/PET scans, MRIs)	50% coinsurance after deductible	Not covered	Prior authorization required
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caresouce.com/marketplace">www.caresouce.com/marketplace</a> .	Preventive drugs	Retail: No charge Mail-Order: No charge	Not covered	Retail: Up to a 30-day supply
	Low cost drugs	Retail: 50% coinsurance after deductible Mail-Order: 50% 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 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](http://www.caresource.com/marketplace) or call 1-855-202-0622.

\*\* In addition to any visits covered under chronic pain treatment benefit.

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)	
	Preferred brand drugs	Retail: 50% coinsurance after deductible Mail-Order: 50% coinsurance after deductible	Not covered	Retail: Up to a 30-day supply  Mail-Order: Up to a 90-day supply for Preventive, Low Cost, and Brand drugs/Up to a 30-day supply for Specialty drugs  Certain drugs may require a prior authorization.
	Non-preferred brand drugs	Retail: 50% coinsurance after deductible Mail-Order: 50% coinsurance after deductible	Not covered	
	<a href="#">Specialty drugs</a> preferred	Retail: 50% coinsurance after deductible Mail-Order: 50% coinsurance after deductible	Not covered	
	<a href="#">Specialty drugs</a> non-preferred	Retail: 50% coinsurance after deductible Mail-Order: 50% coinsurance after deductible	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	50% coinsurance after deductible	Not covered	May require prior authorization
	Physician/surgeon fees	50% coinsurance after deductible	Not covered	May require prior authorization
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	50% coinsurance after deductible	50% coinsurance after deductible	<u>Copayment</u> waived if you are admitted to the hospital directly from the Emergency Department.
	<a href="#">Emergency medical transportation</a>	50% coinsurance after deductible	50% 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.
	<a href="#">Urgent care</a>	50% coinsurance after deductible	50% coinsurance after deductible	If you receive services in addition to <u>urgent care</u> , additional <u>copayments</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.caresource.com/marketplace](http://www.caresource.com/marketplace) or call 1-855-202-0622.

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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	50% coinsurance after deductible	Not covered	Prior authorization required
	Physician/surgeon fees	50% coinsurance after deductible	Not covered	Prior authorization required
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	50% coinsurance after deductible for office visits and 50% 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	50% coinsurance after deductible	Not covered	
<b>If you are pregnant</b>	Office visits	50% coinsurance after deductible	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>
	Childbirth/delivery professional services	50% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	50% coinsurance after deductible	Not covered	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>			Prior authorization required
	Private duty nursing	50% coinsurance after deductible	Not covered	35 visits per benefit year. A visit equals 8 hours or less.
	All other services	50% coinsurance after deductible		100 visits per benefit year. A visit equals at least 4 hours.
	Chronic pain treatment	50% coinsurance after deductible	Not covered	20 combined visits per event

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.caresource.com/marketplace](http://www.caresource.com/marketplace) or call 1-855-202-0622.

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>Rehabilitation services</u>			
	Physical therapy	50% coinsurance after deductible		30 visits per benefit year**
	Occupational therapy	50% coinsurance after deductible		30 visits per benefit year**
	Speech therapy	50% coinsurance after deductible	Not covered	30 visits per benefit year
	Cardiac rehabilitation	50% coinsurance after deductible		36 visits per benefit year
	Chiropractic services	50% coinsurance after deductible		Manipulation therapy - 30 visits per benefit year**
	<u>Habilitation services</u>			
	Physical therapy	50% coinsurance after deductible		30 visits per benefit year**
	Occupational therapy	50% coinsurance after deductible	Not covered	30 visits per benefit year**
	Speech therapy	50% coinsurance after deductible		30 visits per benefit year
	<u>Skilled nursing care</u>	50% coinsurance after deductible	Not covered	Prior authorization required 90 day limit per benefit year
	<u>Durable medical equipment</u>	50% coinsurance after deductible	Not covered	May require prior authorization
<u>Hospice services</u>	50% coinsurance after deductible	Not covered	Prior authorization is required for inpatient, respite, or continuous care levels of care.	
<b>If your child needs dental or eye care</b>	Children's eye exam	50% coinsurance after deductible	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	50% coinsurance after deductible	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	50% coinsurance after deductible	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](http://www.caresource.com/marketplace) or call 1-855-202-0622.

\*\* In addition to any visits covered under chronic pain treatment benefit.

## 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
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Private duty nursing

**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: 1-888-879-9842. 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](http://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 West Virginia Department of Insurance: 1-888-879-9842.

### 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 1-855-202-0622.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-202-0622.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-202-0622.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-202-0622.

————— *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](#) \$5,300
- [Specialist coinsurance](#) 50%
- [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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
---------------------------	-----------------

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

Cost Sharing	
Deductibles	\$1,720
Copayments	\$0
Coinsurance	\$5,030
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,810</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5,300
- [Specialist coinsurance](#) 50%
- [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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
---------------------------	----------------

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

Cost Sharing	
Deductibles	\$3,350
Copayments	\$0
Coinsurance	\$3,400
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$6,805</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$5,300
- [Specialist coinsurance](#) 50%
- [Hospital \(facility\) coinsurance](#) 50%
- [Other coinsurance](#) 50%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,010</b>
---------------------------	----------------

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

Cost Sharing	
Deductibles	\$963
Copayments	\$0
Coinsurance	\$963
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,926</b>

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