



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 1-833-230-2030. 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](http://www.caresource.com/marketplace) or call 1-833-230-2030 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$400 individual/\$800 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> ?	\$750 individual/\$1,500 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 1-833-230-2030 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> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider 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 office</a> or clinic</b>	Zero Cost Telemedicine Partner	No charge	Not covered	Refer to your Evidence of Coverage
	Primary care visit to treat an injury or illness. Mental health/substance abuse, retail clinics, and all other telemedicine.	\$5 copay	Not covered	None
	<a href="#">Specialist</a> visit	\$15 copay	Not covered	None
	<a href="#">Preventive care/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.
<b>If you have a test†</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: \$50 copay after deductible	Not covered	None
		Lab: 5% coinsurance after deductible		None
	Imaging (CT/PET scans, MRIs)	\$100 copay after deductible	Not covered	None

\*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 1-833-230-2030.

†Prior authorization may be required, for more details see [www.caresource.com/mp-GA-pa](http://www.caresource.com/mp-GA-pa).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<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.caresource.com/marketplace">www.caresource.com/marketplace</a> .	Preventive drugs	Retail: No charge Mail-Order: No charge	Not covered	Retail: Up to a 90-day supply for Preventive, Low-cost, Preferred brand, and Non-preferred brand. Up to a 30-day supply for Specialty. Costs shown are for a 30-day supply. Copays for a 90-day supply will be three times the shown amount.  Mail-Order: 90-day supply for Preventive, Low-cost, Preferred brand, and Non-preferred brand. Up to a 30-day supply for Specialty drugs. Copays shown are for a 90-day supply.  You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Low-cost drugs	Retail: Up to \$5 copay Mail-Order: Up to \$12.50 copay	Not covered	
	Preferred brand drugs	Retail: Up to \$15 copay Mail-Order: Up to \$37.50 copay	Not covered	
	Non-preferred brand drugs	Retail/Mail Order: 5% coinsurance after deductible	Not covered	
	<a href="#">Specialty drugs</a> preferred	Retail/Mail Order: 45% coinsurance after deductible	Not covered	
	<a href="#">Specialty drugs</a> non-preferred	Retail/Mail Order: 50% coinsurance after deductible	Not covered	
<b>If you have outpatient surgery†</b>	Facility fee (e.g., ambulatory surgery center)	5% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	5% coinsurance after deductible	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 copay after deductible	\$150 copay after deductible	Emergency room copay or coinsurance is waived if you are admitted to the hospital directly from the Emergency Department.
	<a href="#">Emergency medical transportation</a>	5% coinsurance after deductible	5% coinsurance after deductible	None
	<a href="#">Urgent care</a>	\$25 copay	\$25 copay	If you receive services in addition to <a href="#">urgent care</a> , additional <a href="#">copayments</a> , <a href="#">deductibles</a> , or <a href="#">coinsurance</a> may apply.
<b>If you have a hospital stay†</b>	Facility fee (e.g., hospital room)	\$150 copay after deductible	Not covered	None
	Physician/surgeon fees	\$150 copay after deductible	Not covered	Copay included in facility fee; 1 visit per physician per day

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider 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 5% coinsurance after deductible for other outpatient services	Not covered	None
	Inpatient services	\$150 copay after deductible	Not covered	None
If you are pregnant	Office visits	\$15 copay	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery/facility professional services†	\$150 copay after deductible	Not covered	
	Childbirth/delivery facility services†	\$150 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	<a href="#">Home health care</a> †	5% coinsurance after deductible	Not covered	120 visits per Benefit Year. Refer to your Evidence of Coverage for additional information.
	<a href="#">Rehabilitation services</a> † Physical/Occupational therapy Speech/Post-cochlear implant aural therapy All other services	\$5 copay	Not covered	PT, OT, ST, Manipulation therapy, Post-cochlear implant aural therapy, and Cognitive limited to 40 visits each per Benefit Year..
		5% coinsurance after deductible	Not covered	
		5% coinsurance after deductible	Not covered	
	<a href="#">Habilitation services</a> † Physical/Occupational therapy Speech therapy Audiology	\$5 copay	Not covered	40 combined visits per Benefit Year
		5% coinsurance after deductible	Not covered	40 combined visits per Benefit Year
		5% coinsurance after deductible	Not covered	40 combined visits per Benefit Year

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Manipulation therapy	5% coinsurance after deductible	Not covered	Manipulation therapy limited to 40 combined visits per Benefit Year .
	<u>Autism spectrum disorder services</u> †			
	Physical/Occupational Therapy, Adaptive Behavior Treatment	\$5 copay	Not covered	PT, OT 40 visits each per Benefit Year. ABT includes Applied Behavior Analysis (ABA).
	Speech Therapy	5% coinsurance after deductible	Not covered	Combined limit with Habilitative Services
	<u>Skilled nursing care</u> †	\$150 copay after deductible	Not covered	60 Day limit per Benefit Year
	<u>Durable medical equipment</u> †	5% coinsurance after deductible	Not covered	Refer to your Evidence of Coverage
	<u>Hospice services</u>	5% coinsurance after deductible	Not covered	Refer to your Evidence of Coverage
<b>If your child needs dental or eye care</b>	Children’s eye exam	No charge	Not covered	1 routine eye exam per Benefit Year
	Children’s eyewear	No charge	Not covered	Limited to one pair of glasses or 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 check-ups per Benefit Year. Additional benefits available. Refer to your Evidence of Coverage

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## 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](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 on how 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: Georgia Department of Insurance: 1-800-656-2298.

### 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 the Minimum Value Standards? Not Applicable

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.*

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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 prenatal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$400
- [Specialist copayment](#) \$15
- Hospital (facility) [copayment](#) \$150
- Other [coinsurance](#) 5%

**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>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$760</b>

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$400
- [Specialist copayment](#) \$15
- Hospital (facility) [copayment](#) \$150
- Other [coinsurance](#) 5%

**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>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$820</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$400
- [Specialist copayment](#) \$15
- Hospital (facility) [copayment](#) \$150
- Other [coinsurance](#) 5%

**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>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$760</b>

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