**-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 833-230-2099. 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 833-230-2099 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $300 individual/$600 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?** | $800 individual/$1,600 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 833-230-2099 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. |

| 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 visit a health care provider's office or clinic** | Zero Cost Telemedicine Partner | No charge | Not covered | Refer to your Evidence of Coverage |
| | Primary care visit to treat an injury or illness. | No charge | Not covered | None |
| | Specialist visit | $15 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: $50 copay after deductible | Not covered | None |
| | | Lab: $10 copay | | None |
| | Imaging (CT/PET scans, MRIs) | $100 copay after deductible | Not covered | None |
| **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 | No charge | Not covered | Up to a 90-day supply when filled at: Retail for Generic Drugs in Tiers 0-3 Mail Order for any drug in Tiers 0-3 All others limited to a 30-day supply Any copays shown are for a 30-day supply. 90-day supplies for Retail are 3 times the copay and for Mail Order are 2.5 times the copay. |
| | Generic drugs | Up to $5 copay | Not covered | |
| | Preferred brand drugs | Up to $25 copay | Not covered | |
| | Non-preferred brand drugs | 30% coinsurance after deductible | Not covered | |
| | Specialty drugs | 45% coinsurance after deductible | Not covered | |
| **If you have outpatient surgery†** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance after deductible | Not covered | None |
| | Physician/surgeon fees | 10% coinsurance after deductible | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | $300 copay after deductible | $300 copay after deductible | Emergency room copay or coinsurance is waived if you are admitted to the hospital directly from the Emergency Department. |
| | Emergency medical transportation | 10% coinsurance after deductible | 10% coinsurance after deductible | None |

*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 833-230-2099.
†Prior authorization may be required, for more details see 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) | |
| | Urgent care | $25 copay | $25 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) | $300 copay after deductible per stay | Not covered | None |
| | Physician/surgeon fees | No charge after deductible | Not covered | 1 visit per physician per day |
| **If you need mental health, behavioral health, or substance abuse services†** | Outpatient services | No charge for office visits and 10% coinsurance after deductible for other outpatient services | Not covered | None |
| | Inpatient services | $300 copay after deductible per stay | 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, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services† | No charge after deductible | Not covered | |
| | Childbirth/delivery facility services† | $300 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† | 10% coinsurance after deductible | Not covered | 120 visits per Benefit Year. Refer to your Evidence of Coverage for additional information. |
| | Rehabilitation services†<br>Physical/Occupational therapy<br>Speech/Post-cochlear implant aural therapy<br>All other services | <br>No charge<br>10% coinsurance after deductible<br>10% coinsurance after deductible | <br>Not covered<br>Not covered<br>Not covered | PT, OT, ST, Manipulation therapy, Post-cochlear implant aural therapy, Cognitive limited to 40 visits each per Benefit Year. |

*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 833-230-2099.
†Prior authorization may be required, for more details see 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) | |
| | Habilitation services† | | | |
| | Physical/Occupational therapy | No charge | Not covered | 40 combined visits per Benefit Year |
| | Speech therapy | 10% coinsurance after deductible | Not covered | 40 combined visits per Benefit Year |
| | Audiology | 10% coinsurance after deductible | Not covered | 40 combined visits per Benefit Year |
| | Manipulation therapy | 10% coinsurance after deductible | Not covered | Manipulation therapy limited to 40 combined visits per Benefit Year. |
| | Skilled nursing care† | $200 copay after deductible per stay | Not covered | 60 Day limit per Benefit Year |
| | Durable medical equipment† | 10% coinsurance after deductible | Not covered | Refer to your Evidence of Coverage |
| | Hospice services | 10% coinsurance after deductible | Not covered | Refer to your Evidence of Coverage |
| **If your child needs dental or eye care** | 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 |

## 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

*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 833-230-2099.
†Prior authorization may be required, for more details see www.caresource.com/mp-GA-pa.

| 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 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 833-230-2099

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-230-2099

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 833-230-2099

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833-230-2099.

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



*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 833-230-2099.
†Prior authorization may be required, for more details see www.caresource.com/mp-GA-pa.

**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 | $300 |
| Specialist copayment | $15 |
| Hospital (facility) copayment | $300 |
| 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 | $12,700 |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $300 |
| Copayments | $300 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$860** |

## Managing Joe's Type 2 Diabetes

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

| | |
|---|---|
| The plan's overall deductible | $300 |
| Specialist copayment | $15 |
| Hospital (facility) copayment | $300 |
| 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 | $5,600 |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $300 |
| Copayments | $200 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$820** |

## Mia's Simple Fracture

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

| | |
|---|---|
| The plan's overall deductible | $300 |
| Specialist copayment | $15 |
| Hospital (facility) copayment | $300 |
| 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 | $2,800 |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $300 |
| Copayments | $400 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$800** |

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