



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 844-539-1733. 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 [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary).

| Important Questions                                                             | Answers                                                                                                                                                            | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$3,000 individual/\$6,000 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> ? | \$8,500 individual/\$17,000 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 844-539-1733 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> ).*  |
| 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> .                                                                                                                                                                                                                                                                                                                                                                     |

\*Balance billing does not apply in West Virginia.  
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| Common Medical Event                                                                                                                                                                                                                   | Services You May Need                                   | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Network Provider Information*                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                        |                                                         | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                             |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                          | Teladoc                                                 | No charge                                    | Not covered                                        | Refer to your Evidence of Coverage                                                                                                                                                                          |
|                                                                                                                                                                                                                                        | Primary care visit to treat an injury or illness.       | \$10 copay                                   | Not covered                                        | None                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                        | <a href="#">Specialist</a> visit                        | \$40 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: 30% coinsurance after deductible      | Not covered                                        | None                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                        |                                                         | Lab: \$30 copay                              |                                                    | None                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                        | Imaging (CT/PET scans, MRIs)                            | 30% coinsurance after deductible             | Not covered                                        | None                                                                                                                                                                                                        |
| <b>If you need drugs to treat your illness or condition†</b><br>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                                        | No charge                                    | Not covered                                        | Up to a 30-day supply for Specialty Drugs<br>Up to a 90-day supply for all other Retail and Mail Order.                                                                                                     |
|                                                                                                                                                                                                                                        | Generic drugs                                           | Up to \$10 copay                             | Not covered                                        |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                        | Preferred brand drugs                                   | Up to \$60 copay                             | Not covered                                        |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                        | Non-preferred brand drugs                               | 30% coinsurance after deductible             | Not covered                                        | Any copays shown are for a 30-day supply. 90-day supplies available at 3 times the copay.<br>Insulin cost share not to exceed \$35 and diabetic devices not to exceed \$100 per 30-day supply in aggregate. |
|                                                                                                                                                                                                                                        | <a href="#">Specialty drugs</a>                         | 40% coinsurance after deductible             | Not covered                                        |                                                                                                                                                                                                             |
| <b>If you have outpatient surgery†</b>                                                                                                                                                                                                 | Facility fee (e.g., ambulatory surgery center)          | 30% coinsurance after deductible             | Not covered                                        | None                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                        | Physician/surgeon fees                                  | 30% coinsurance after deductible             | Not covered                                        | None                                                                                                                                                                                                        |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                         | <a href="#">Emergency room care</a>                     | 10% coinsurance after deductible             | 10% coinsurance after deductible                   | Emergency room copay or coinsurance is waived if you are admitted to the hospital directly from the Emergency Department.                                                                                   |

\*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 844-539-1733.

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

\*\*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 Network Provider Information*                                                                                                                                                        |
|-----------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                   |                                                  | Network Provider<br>(You will pay the least)                                                    | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                 |
|                                                                                   | <a href="#">Emergency medical transportation</a> | 30% coinsurance after deductible                                                                | 30% coinsurance after deductible                   | None                                                                                                                                                                                                                            |
|                                                                                   | <a href="#">Urgent care</a>                      | \$30 copay                                                                                      | \$30 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)               | \$500 copay after deductible per stay                                                           | Not covered                                        | None                                                                                                                                                                                                                            |
|                                                                                   | Physician/surgeon fees                           | No charge after deductible                                                                      | Not covered                                        | 1 visit per physician per day                                                                                                                                                                                                   |
| <b>If you need mental health, behavioral health, or substance abuse services†</b> | Outpatient services                              | \$10 copay for office visits and 30% coinsurance after deductible for other outpatient services | Not covered                                        | None                                                                                                                                                                                                                            |
|                                                                                   | Inpatient services                               | \$500 copay after deductible per stay                                                           | Not covered                                        | None                                                                                                                                                                                                                            |
| <b>If you are pregnant</b>                                                        | Office visits                                    | \$40 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 professional services†       | No charge 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.                                                                                                                                                |

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\*\*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 Network Provider Information*                                                                                                      |
|-----------------------------------------------------------------------|---------------------------------------------|----------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                             | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                               |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a> †          | 30% coinsurance after deductible             | Not covered                                        | Private-Duty Nursing limited to 35 visits per Benefit Year. 100 visits per Benefit Year for other services.<br>Refer to your Evidence of Coverage for additional information. |
|                                                                       | <a href="#">Rehabilitation services</a> †   |                                              |                                                    |                                                                                                                                                                               |
|                                                                       | Physical/Occupational therapy               | \$10 copay                                   | Not covered                                        | PT**, OT**, Manipulation therapy**, Pulmonary limited to 30 visits each per Benefit Year. Cardiac limited to 36 visits.                                                       |
|                                                                       | Speech therapy                              | \$10 copay                                   | Not covered                                        |                                                                                                                                                                               |
|                                                                       | Post-cochlear implant aural therapy         | \$10 copay                                   | Not covered                                        |                                                                                                                                                                               |
|                                                                       | All other services                          | 30% coinsurance after deductible             | Not covered                                        |                                                                                                                                                                               |
|                                                                       | <a href="#">Habilitation services</a> †     |                                              |                                                    |                                                                                                                                                                               |
|                                                                       | Physical/Occupational therapy               | \$10 copay                                   | Not covered                                        | 30 visits each per Benefit Year                                                                                                                                               |
|                                                                       | Speech therapy                              | \$10 copay                                   | Not covered                                        | None                                                                                                                                                                          |
|                                                                       | Manipulation therapy                        | 30% coinsurance after deductible             | Not covered                                        | 30 visits per Benefit Year**                                                                                                                                                  |
|                                                                       | Chronic pain treatment                      | \$10 copay                                   | Not covered                                        | 20 combined visits per event                                                                                                                                                  |
|                                                                       | <a href="#">Skilled nursing care</a> †      | 30% coinsurance after deductible             | Not covered                                        | None                                                                                                                                                                          |
|                                                                       | <a href="#">Durable medical equipment</a> † | 30% coinsurance after deductible             | Not covered                                        | Refer to your Evidence of Coverage                                                                                                                                            |
|                                                                       | <a href="#">Hospice services</a>            | 30% coinsurance after deductible             | Not covered                                        | Refer to your Evidence of Coverage                                                                                                                                            |

\*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 844-539-1733.

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\*\*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 Network Provider Information*                                                                                                                                                                   |
|----------------------------------------|----------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                            |
| 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. Refer to your Evidence of Coverage for additional eyewear options that may have an additional charge. |
|                                        | Children's dental check-up | Not covered                                  | Not covered                                        |                                                                                                                                                                                                                                            |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                            |                                                                                                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>Acupuncture</li> <li>Cosmetic surgery</li> </ul>         | <ul style="list-style-type: none"> <li>Dental care</li> <li>Hearing aids</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S</li> <li>Routine eye care (Adult)</li> <li>Weight loss programs</li> </ul> |  |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |                                                                        |                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Chiropractic care</li> </ul>                                               | <ul style="list-style-type: none"> <li>Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>Routine foot care</li> </ul> |

**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 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: West Virginia Department of Insurance: 1-888-879-9842.

#### 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](#).

\*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 844-539-1733.

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

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### 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 844-539-1733

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-539-1733

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-539-1733

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 844-539-1733.

You may view the Access Plan required by Health Benefit Plan Network Access and Adequacy Act online at [CareSource.com]. You may also contact us at 1-833-230-2099 to request a copy.

*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](http://www.caresource.com/marketplace) or call 844-539-1733.

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

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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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$500   |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

*Cost Sharing*

|                             |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$3,000 |
| <a href="#">Copayments</a>  | \$600   |
| <a href="#">Coinsurance</a> | \$0     |

*What isn't covered*

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$3,600</b> |
|-----------------------------------|----------------|

### Managing Joe's Type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$500   |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

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> |
|---------------------------|----------------|

In this example, Joe would pay:

*Cost Sharing*

|                             |       |
|-----------------------------|-------|
| <a href="#">Deductibles</a> | \$0   |
| <a href="#">Copayments</a>  | \$100 |
| <a href="#">Coinsurance</a> | \$0   |

*What isn't covered*

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Joe would pay is</b> | <b>\$100</b> |
|-----------------------------------|--------------|

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$500   |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

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> |
|---------------------------|----------------|

In this example, Mia would pay:

*Cost Sharing*

|                             |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$2,300 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$0     |

*What isn't covered*

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$2,300</b> |
|-----------------------------------|----------------|

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