



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 1-877-806-9284. 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 1-877-806-9284 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$350 individual/\$700 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> ?	\$700 individual/\$1,400 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, adult dental and vision cost sharing 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 1-877-806-9284 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 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	None
	<a href="#">Specialist</a> visit	\$15 copay	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	No charge	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.
If you have a test†	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: \$50 copay after deductible Lab: 5% coinsurance after deductible	Not covered	None 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 1-877-806-9284.

†Prior authorization may be required for payment of claim

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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)	
<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 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.  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: No charge Mail-Order: No charge	Not covered	
	Preferred brand drugs	Retail: \$10 copay Mail-Order: \$25 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/physician/surgeon fee (e.g., ambulatory surgery center)	5% coinsurance after deductible	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	5% coinsurance after deductible	5% coinsurance after deductible	If admitted to the hospital directly from the Emergency Department, these services will be covered the same as inpatient services and the applicable copayment and coinsurance will apply.
	<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/physician/surgeon fee (e.g., hospital room)	\$150 copay after deductible	Not covered	None

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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	No charge 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	<a href="#">Copayment</a> covers initial physician visit and all subsequent prenatal visits, postnatal visits, and physician delivery charges covered under the Global Maternity Fee. Additional <a href="#">copayments</a> , <a href="#">deductibles</a> , or <a href="#">coinsurance</a> may apply depending on services rendered in addition to the Global Maternity Fee.  Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</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	100 visits per benefit year. Refer to your Evidence of Coverage for additional information.
	<a href="#">Rehabilitation services</a> †			
	Physical/Occupational therapy	No charge	Not covered	PT, OT, ST, Pulmonary limited to 20 visits each per benefit year. Cardiac limited to 36 visits. Manipulation therapy limited to 12 visits. Post-cochlear implant aural therapy combined limit with ST.
	Speech therapy	5% coinsurance after deductible	Not covered	
	All other services	5% coinsurance after deductible	Not covered	

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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)	
	<u>Habilitation services</u> † Physical/Occupational therapy	No charge	Not covered	20 visits per benefit year for each
	Speech therapy	5% coinsurance after deductible	Not covered	20 visits per benefit year
	<u>Autism spectrum disorder services</u> † Physical/Occupational/Behavioral Therapy	No charge	Not covered	Combined limit with Habilitative Services. BT includes Applied Behavioral 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	90 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
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	\$0 copay	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.)

- |  |   |   |
|--|---|---|
| <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>• Bariatric surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Cosmetic surgery</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 foot care</li> <li>• Weight loss programs</li> </ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic care
- Dental care (Adult)
  - \$0 copay for preventive services
  - 10% coinsurance for basic restorative services
  - 35% coinsurance for major restorative services
  - \$800 limit per benefit year
- Fitness Benefits - Gym Membership or At home kits
- Private duty nursing
- Routine eye care (Adult)
  - \$250 limit per benefit year for glasses or contacts

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-622-4461. 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: Indiana Department of Insurance: 1-800-622-4461.

**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 1-877-806-9284

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-806-9284

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-806-9284

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-806-9284.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$350
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">copayment</a>	\$150
■ Other <a href="#">coinsurance</a>	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:

*Cost Sharing*

<a href="#">Deductibles</a>	\$350
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$200

*What isn't covered*

Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$710</b>
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### 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>	\$350
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">copayment</a>	\$150
■ Other <a href="#">coinsurance</a>	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:

*Cost Sharing*

<a href="#">Deductibles</a>	\$350
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$200

*What isn't covered*

Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$600</b>
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### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$350
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">copayment</a>	\$150
■ Other <a href="#">coinsurance</a>	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:

*Cost Sharing*

<a href="#">Deductibles</a>	\$350
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$80

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$530</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services