



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

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall deductible ? | \$450 individual/\$900 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 ? | \$900 individual/\$1,800 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, adult dental and vision cost sharing 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 1-877-806-9284 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 . |

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 provider's office or clinic | Primary care visit to treat an injury or illness | \$5 copay | Not covered | None |
| | Specialist visit | \$15 copay | Not covered | Plan covers 100% of allowed amount in excess of the copayment . Copayment waived when the only charge is for allergy injections/serum. If you receive services in addition to office visits, additional copayments , deductibles , or coinsurance may apply. |
| | Other practitioner office visit Nurse practitioner/retail clinic | \$5 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 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 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) | |
| 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 | 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: \$5 copay Mail-Order: \$12.50 copay | Not covered | |
| | Preferred brand drugs | Retail: \$15 copay Mail-Order: \$37.50 copay | Not covered | |
| | Non-preferred brand drugs | Retail/Mail Order: 5% coinsurance after deductible | Not covered | |
| | Specialty drugs preferred | Retail/Mail Order: 45% coinsurance after deductible | Not covered | |
| | Specialty drugs non-preferred | Retail/Mail Order: 50% coinsurance after deductible | Not covered | |
| If you have outpatient surgery† | Facility/physician/surgeon fee (e.g., ambulatory surgery center) | 5% coinsurance after deductible | Not covered | None |
| If you need immediate medical attention | Emergency room care | 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. |
| | Emergency medical transportation | 5% coinsurance after deductible | 5% coinsurance after deductible | None |
| | Urgent care | \$75 copay | \$75 copay | If you receive services in addition to urgent care , additional copayments , deductibles , or coinsurance may apply. |
| If you have a hospital stay† | Facility/physician/surgeon fee (e.g., hospital room) | \$200 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 | \$5 copay for office visits and 5% coinsurance after deductible for other outpatient services | Not covered | None |
| | Inpatient services | \$200 copay after deductible | Not covered | None |
| If you are pregnant | Office visits | \$15 copay | Not covered | Copayment covers initial physician visit and all subsequent prenatal visits, postnatal visits, and physician delivery charges covered under the Global Maternity Fee. Additional copayments , deductibles , or coinsurance may apply depending on services rendered in addition to the Global Maternity Fee. Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery/facility professional services† | \$200 copay after deductible | Not covered | |
| | Childbirth/delivery facility services† | \$200 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 † | 5% coinsurance after deductible | Not covered | 100 visits per benefit year. Refer to your Evidence of Coverage for additional information. |
| | Rehabilitation services † | | | |
| | Physical/Occupational therapy | \$5 copay | 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 | \$5 copay | 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 | \$5 copay | 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> † | \$200 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 | \$15 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.)

- | | | |
|--|-------------------------|--|
| • Abortion (Except in cases of rape, incest, or when the life of the mother is endangered) | • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. |
| • Acupuncture | • Hearing aids | • Routine foot care |
| • Bariatric surgery | • Infertility treatment | • Weight loss programs |
| | • Long term care | |

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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)
 - \$15 copay for preventive services
 - 20% coinsurance for basic restorative services
 - 40% 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 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 plan's overall deductible | \$450 |
| ■ Specialist copayment | \$15 |
| ■ Hospital (facility) copayment | \$200 |
| ■ 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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------|-------|
| Deductibles | \$450 |
| Copayments | \$200 |
| Coinsurance | \$200 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|--------------|
| The total Peg would pay is | \$910 |
|-----------------------------------|--------------|

Managing Joe's Type 2 Diabetes

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$450 |
| ■ Specialist copayment | \$15 |
| ■ Hospital (facility) copayment | \$200 |
| ■ 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------|-------|
| Deductibles | \$450 |
| Copayments | \$200 |
| Coinsurance | \$200 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$20 |
|----------------------|------|

| | |
|-----------------------------------|--------------|
| The total Joe would pay is | \$870 |
|-----------------------------------|--------------|

Mia's Simple Fracture

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$450 |
| ■ Specialist copayment | \$15 |
| ■ Hospital (facility) copayment | \$200 |
| ■ 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------|-------|
| Deductibles | \$450 |
| Copayments | \$200 |
| Coinsurance | \$80 |

What isn't covered

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

| | |
|-----------------------------------|--------------|
| The total Mia would pay is | \$730 |
|-----------------------------------|--------------|

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