



-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 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](http://www.caresource.com/marketplace) or call 833-230-2099 to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| What is the overall <a href="#">deductible</a> ?                                | \$300 individual/\$600 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> ? | \$800 individual/\$1,600 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 833-230-2099 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No   | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .   |

| Common Medical Event   | Services You May Need                                   | What You Will Pay   |   | Limitations, Exceptions, & Other Important Network Provider Information*  |
|--|---|---|---|---|
|  |   | Network Provider<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>  | Zero Cost Telehealth 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  |
|  | <a href="#">Specialist</a> visit                        | \$15 copay  | Not covered   | None  |
|  | <a href="#">Preventive care/screening</a> /immunization | No charge   | Not covered   | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.   |
| <b>If you have a test†</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)     | X-ray: \$50 copay after deductible  | Not covered   | None  |
|  |   | Lab: \$10 copay   |   | None  |
|  | Imaging (CT/PET scans, MRIs)                            | \$100 copay 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 90-day supply when filled at:<br>Retail for Generic Drugs in Tiers 0-3<br>Mail Order for any drug in Tiers 0-3<br>All others limited to a 30-day supply<br>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   |   |
|  | <a href="#">Specialty drugs</a>                         | 45% coinsurance after deductible  | Not covered   |   |
| <b>If you have outpatient surgery†</b>   | Facility fee (e.g., ambulatory surgery center)          | 10% coinsurance after deductible  | Not covered   | None  |
|  | Physician/surgeon fees                                  | 10% coinsurance after deductible  | Not covered   | None  |
| <b>If you need immediate medical attention</b>   | <a href="#">Emergency room care</a>                     | \$300 copay after deductible for both in-network and out-of-network providers | \$300 copay after deductible for both in-network and out-of-network providers | 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 833-230-2099.

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

| 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>                           | 10% coinsurance after deductible for both in-network and out-of-network providers              | 10% coinsurance after deductible for both in-network and out-of-network providers | 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.  |
| 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, <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†                                     | \$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             | <a href="#">Home health care</a> †   | 10% coinsurance after deductible   | Not covered   | 100 visits per Benefit Year. Refer to your Evidence of Coverage for additional information.   |
|  | <a href="#">Rehabilitation services</a> †<br>Physical/Occupational therapy | No charge  | Not covered   | PT, OT, ST, Pulmonary, Cognitive limited to 20 visits each per Benefit Year. Cardiac  |

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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) |   |
|  | Speech/Post-cochlear implant aural therapy  | 10% coinsurance after deductible             | Not covered  | limited to 36 visits. Manipulation therapy limited to 12 visits. Post-cochlear implant aural therapy limited to 30 visits.                                |
|  | All other services                          | 10% coinsurance after deductible             | Not covered  |   |
|  | <a href="#">Habilitation services</a> †     |  |  |   |
|  | Physical/Occupational therapy               | No charge                                    | Not covered  | 20 visits per Benefit Year  |
|  | Speech therapy                              | 10% coinsurance after deductible             | Not covered  | 20 visits per Benefit Year  |
|  | <a href="#">Skilled nursing care</a> †      | \$200 copay after deductible per stay        | Not covered  | 90 Day limit per Benefit Year   |
|  | <a href="#">Durable medical equipment</a> † | 10% coinsurance after deductible             | Not covered  | Refer to your Evidence of Coverage  |
|  | <a href="#">Hospice services</a>            | 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 a 12-month supply of 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 <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>• Bariatric surgery</li></ul>      | <ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li><li>• Hearing Aids</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>• Routine foot care</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>• Chiropractic care</li></ul>   | <ul style="list-style-type: none"><li>• Infertility treatment</li></ul>  | <ul style="list-style-type: none"><li>• Private duty nursing</li></ul>  |

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**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: 1-800-686-1526. 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: Ohio Department of Insurance: 1-800-686-1526.

**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, kwijigo holne' 833-230-2099.

*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> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$15  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$300 |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

##### *Cost Sharing*

|                             |       |
|-----------------------------|-------|
| <a href="#">Deductibles</a> | \$300 |
| <a href="#">Copayments</a>  | \$300 |
| <a href="#">Coinsurance</a> | \$200 |

##### *What isn't covered*

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

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Peg would pay is</b> | <b>\$860</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> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$15  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$300 |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

##### *Cost Sharing*

|                             |       |
|-----------------------------|-------|
| <a href="#">Deductibles</a> | \$300 |
| <a href="#">Copayments</a>  | \$200 |
| <a href="#">Coinsurance</a> | \$300 |

##### *What isn't covered*

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

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Joe would pay is</b> | <b>\$820</b> |
|-----------------------------------|--------------|

### Mia's Simple Fracture

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

|   |       |
|---|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$15  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$300 |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

##### *Cost Sharing*

|                             |       |
|-----------------------------|-------|
| <a href="#">Deductibles</a> | \$300 |
| <a href="#">Copayments</a>  | \$400 |
| <a href="#">Coinsurance</a> | \$100 |

##### *What isn't covered*

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

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Mia would pay is</b> | <b>\$800</b> |
|-----------------------------------|--------------|

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