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 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$700 individual/$1,400 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?	$3,300 individual/$6,600 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.caresource.com/marketplace or call 844-539-1733 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).*
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

*Balance billing does not apply in West Virginia.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Network Provider Information*
If you visit a health care provider's office or clinic	Teladoc	No charge	Not covered	Refer to your Evidence of Coverage
	Primary care visit to treat an injury or illness.	$20 copay	Not covered	None
	Specialist visit	$40 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: 30% coinsurance after deductible	Not covered	None
		Lab: 30% coinsurance after deductible		None
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	Not covered	None
If you need drugs to treat your illness or condition† More information about **prescription drug coverage** is available at www.caresource.com/marketplace.	Preventive drugs	No charge	Not covered	Up to a 30-day supply for Specialty Drugs Up to a 90-day supply for all other Retail and Mail Order. Any copays shown are for a 30-day supply. 90-day supplies available at 3 times the copay. Insulin cost share not to exceed $35 and diabetic devices not to exceed $100 per 30-day supply in aggregate.
	Generic drugs	Up to $10 copay	Not covered	
	Preferred brand drugs	Up to $20 copay	Not covered	
	Non-preferred brand drugs	Up to $60 copay after deductible	Not covered	
	Specialty drugs	Up to $250 copay after deductible	Not covered	
If you have outpatient surgery†	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	30% coinsurance after deductible	Not covered	None
If you need immediate medical attention	Emergency room care	30% coinsurance after deductible	30% 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 or call 844-539-1733.
†Prior authorization may be required, for more details see 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	30% coinsurance after deductible	30% coinsurance after deductible	None
	Urgent care	$30 copay	$30 copay	If you receive services in addition to urgent care, additional copayments, deductibles, or coinsurance may apply.
If you have a hospital stay†	Facility fee (e.g., hospital room)	30% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	30% coinsurance after deductible	Not covered	1 visit per physician per day
If you need mental health, behavioral health, or substance abuse services†	Outpatient services	$20 copay for office visits and 30% coinsurance after deductible for other outpatient services	Not covered	None
	Inpatient services	30% coinsurance after deductible	Not covered	None
If you are pregnant	Office visits	$40 copay	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services†	30% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services†	30% coinsurance after deductible	Not covered	Your cost for inpatient services only. See above for physician delivery charges.

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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 help recovering or have other special health needs	Home health care†	30% coinsurance after deductible	Not covered	Private-Duty Nursing limited to 35 visits per Benefit Year. 100 visits per Benefit Year for other services. Refer to your Evidence of Coverage for additional information.
	Rehabilitation services† Physical/Occupational therapy Speech therapy Post-cochlear implant aural therapy All other services	 $20 copay $20 copay $20 copay 30% coinsurance after deductible	 Not covered Not covered Not covered Not covered	PT**, OT**, Manipulation therapy**, Pulmonary limited to 30 visits each per Benefit Year. Cardiac limited to 36 visits.
	Habilitation services† Physical/Occupational therapy Speech therapy Manipulation therapy	 $20 copay $20 copay 30% coinsurance after deductible	 Not covered Not covered Not covered	 30 visits each per Benefit Year None 30 visits per Benefit Year**
	Chronic pain treatment	$20 copay	Not covered	20 combined visits per event
	Skilled nursing care†	30% coinsurance after deductible	Not covered	None
	Durable medical equipment†	30% coinsurance after deductible	Not covered	Refer to your Evidence of Coverage
	Hospice services	30% coinsurance after deductible	Not covered	Refer to your Evidence of Coverage

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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 (You will pay the least)	Out-of-Network Provider (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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Private-duty nursing
- Routine foot care

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 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 or call 844-539-1733.

†Prior authorization may be required, for more details see www.caresource.com/mp-WV-pa.

**In addition to any visits covered under chronic pain treatment benefit

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, kwiijigo 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 or call 844-539-1733.
†Prior authorization may be required, for more details see www.caresource.com/mp-WV-pa.
**In addition to any visits covered under chronic pain treatment benefit

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** **$700**
- **Specialist *copayment*** **$40**
- **Hospital (facility) *coinsurance*** **30%**
- **Other *coinsurance*** **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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$700
Copayments	$50
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,150**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$700**
- **Specialist *copayment*** **$40**
- **Hospital (facility) *coinsurance*** **30%**
- **Other *coinsurance*** **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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,200**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$700**
- **Specialist *copayment*** **$40**
- **Hospital (facility) *coinsurance*** **30%**
- **Other *coinsurance*** **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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$700
Copayments	$100
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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