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 1-800-479-9502. 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 1-800-479-9502 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$6,650 individual/$13,300 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?	$7,350 individual/ $14,700 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 1-800-479-9502 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 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	$35/visit	Not covered.	No deductible. You only pay the copay.
	Specialist visit	$75/visit	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 Chiropractor	$35/visit 40% coinsurance after deductible	Not covered.	No deductible. You only pay the copay. Manipulation therapy - 12 visits per benefit year.
	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: 40% coinsurance after deductible Lab: 40% coinsurance after deductible	Not covered.	None.
	Imaging (CT/PET scans, MRIs)	40% coinsurance after deductible	Not covered.	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important 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 31-day supply. Mail-Order: Up to a 90-day supply. Certain drugs may require a prior authorization. You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Generic drugs	Retail: $35 copay Mail-Order: $87.50 copay	Not covered.	Retail: Up to a 31-day supply. Mail-Order: Up to a 90-day supply. Certain drugs may require a prior authorization. You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Preferred brand drugs	Retail: 35% coinsurance after deductible Mail-Order: 35% coinsurance after deductible	Not covered.	Retail: Up to a 31-day supply. Mail-Order: Up to a 90-day supply. Certain drugs may require a prior authorization. You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Non-preferred brand drugs	Retail: 40% coinsurance after deductible Mail-Order: 40% coinsurance after deductible	Not covered.	Retail: Up to a 31-day supply. Mail-Order: Up to a 90-day supply. Certain drugs may require a prior authorization. You may be required to use a lower cost drug(s) prior to benefits under your policy

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				being available for certain prescribed drugs.
	Specialty drugs	Retail: 45% coinsurance after deductible Mail-Order: 45% coinsurance after deductible	Not covered.	Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. Certain drugs may require a prior authorization. You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Specialty drugs non-preferred	Retail: Not Applicable Mail-Order: Not Applicable	Not covered.	Retail: Not Applicable. Mail-Order: Not Applicable. Certain drugs may require a prior authorization. You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance after deductible	Not covered.	Prior authorization required.
	Physician/surgeon fees	40% coinsurance after deductible	Not covered.	None.
If you need immediate medical attention	Emergency room care	40% coinsurance after deductible	40% coinsurance after deductible	Copayment waived if you are admitted to the hospital directly from the Emergency Department.
	Emergency medical transportation	40% coinsurance after deductible	40% coinsurance after deductible	None.
	Urgent care	$75/visit	$75/visit	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)	40% coinsurance after deductible	Not covered.	Prior authorization required.
	Physician/surgeon fees	40% coinsurance after deductible	Not covered.	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important 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	$35/visit for office visits and 40% coinsurance after deductible for other outpatient services	Not covered.	Prior authorization required for all inpatient stays, partial hospitalization programs, and intensive outpatient services.
	Inpatient services	40% coinsurance after deductible	Not covered.	
If you are pregnant	Office visits	$75/visit	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 professional services	40% coinsurance after deductible	Not covered.	
	Childbirth/delivery facility services	40% coinsurance 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	40% coinsurance after deductible	Not covered.	100 combined visits per benefit year.
	Autism		Not covered.	
	Occupational therapy	40% coinsurance after deductible		20 visits per benefit year.
	Speech therapy	40% coinsurance after deductible		20 visits per benefit year.
	Behavioral therapy	$35/visit		
	Rehabilitation services		Not covered.	
	Physical therapy	40% coinsurance after deductible		20 visits per benefit year.
	Occupational therapy	40% coinsurance after deductible		20 visits per benefit year.

* For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 1-800-479-9502.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Speech therapy	40% coinsurance after deductible		20 visits per benefit year.
	Cardiac rehabilitation	40% coinsurance after deductible		36 visits per benefit year.
	Chiropractic services	40% coinsurance after deductible		Manipulation therapy - 12 visits per benefit year.
	Habilitation services Physical therapy	40% coinsurance after deductible	Not covered.	20 visits per benefit year.
	Occupational therapy	40% coinsurance after deductible		20 visits per benefit year.
	Speech therapy	40% coinsurance after deductible		20 visits per benefit year.
	Skilled nursing care	40% coinsurance after deductible	Not covered.	Any combination of benefits for skilled nursing facility/inpatient rehabilitation services is limited to 90 days per calendar year.
	Private duty nursing	40% coinsurance after deductible	Not covered.	100 combined visits per benefit year. A visit equals 15 minutes to 8 hours of service.
	Durable medical equipment	40% coinsurance after deductible	Not covered.	May require prior authorization.
	Hospice services	40% coinsurance after deductible	Not covered.	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered.	One routine eye exam per benefit year.
	Low vision exam	40% coinsurance after deductible	Not covered.	1 exam and follow-up visit every 5 years.
	Children's eye wear	No charge	Not covered.	Limited to 1 pair per benefit year and 1 replacement pair if medically necessary.
	Children's dental	$35/visit for preventive 40% coinsurance for basic and major restorative services 50% coinsurance for orthodontic services	Not covered.	2 dental check-ups per benefit year. No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of $1,700.

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
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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), if optional Dental + Vision is selected:
  - $35 copay for preventive services
  - 40% coinsurance for basic and major restorative services
  - $800 annual maximum
- Infertility treatment
- Private duty nursing
- Routine eye care (Adult)
- If optional Dental + Vision is selected:
  - $250 annual maximum 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: 1-800-686-1526. 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 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 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 the Ohio Department of Insurance: 1-800-686-1526.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
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 1-800-479-9502.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-479-9502.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-479-9502.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-479-9502.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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	$6,650
Specialist *copayment*	$75
Hospital (facility) *coinsurance*	40%
Other *coinsurance*	40%

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	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,390
Copayments	$0
Coinsurance	$4,960
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7,410

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

The plan's overall deductible	$6,650
Specialist *copayment*	$75
Hospital (facility) *coinsurance*	40%
Other *coinsurance*	40%

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	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,445
Copayments	$1,515
Coinsurance	$1,998
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$7,013

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

The plan's overall deductible	$6,650
Specialist *copayment*	$75
Hospital (facility) *coinsurance*	40%
Other *coinsurance*	40%

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	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles	$979
Copayments	$225
Coinsurance	$653
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,857

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

If you, or someone you're helping, have questions about CareSource, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-479-9502 TTY:711.

ARABIC
إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوص CareSource، فيحق لك الحصول على مساعدة ومعلومات مجانًا وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، اتصل على 1-800-479-9502 TTY:711.

AMHARIC
እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ CareSource ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-800-479-9502 TTY:711 ይደውሉ።

BURMESE
CareSource အကြောင်း သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်စုံတစ်ယောက်က မေးမြန်းလာပါက သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ ဘာသာပြန်တစ်ဦးအား စကားပြောဆိုရန် 1-800-479-9502 TTY:711 ကျေတွင် နံပါတ်ဖြည့်သွင်းပါ] သို့ ခေါ်ဆိုပါ။

CHINESE
如果您或者您在帮助的人对 CareSource 存有疑问，您有权免费获得以您的语言提供的帮助和信息。 如果您需要与一位翻译交谈，请致电 1-800-479-9502 TTY:711。

CUSHITE – OROMO
Isin yookan namni biraa isin deeggartan CareSource irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-800-479-9502 TTY:711 tiin bilbilaa.

DUTCH
Als u, of iemand die u helpt, vragen heeft over CareSource, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk, bel dan naar 1-800-479-9502 TTY:711.

FRENCH (CANADA)
Des questions au sujet de CareSource? Vous ou la personne que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète, veuillez téléphoner au 1-800-479-9502 TTY:711.

GERMAN
Wenn Sie, oder jemand dem Sie helfen, eine Frage zu CareSource haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, rufen Sie die Nummer 1-800-479-9502 TTY:711 an.

GUJARATI જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તેમ ાંથી કોઈને CareSource વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ચ વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર છે. ૬ ભ વષર્ો િ ત કરિ મ ટે,આ 1-800-479-9502 TTY:711 પર કોલ કરો.

HINDI
यदि आपके, या आप जिसकी मदद कर रहे हैं उसके CareSource के बारे में कोई सवाल हैं तो आपके पास बगैर किसी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिए से बात करने के लिए कॉल करें, 1-800-479-9502 TTY:711.

ITALIAN
Se Lei, o qualcuno che Lei sta aiutando, ha domande su CareSource, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete, chiami il 1-800-479-9502 TTY:711.

JAPANESE
ご本人様、または身の回りの方で、CareSource に関するご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます（無償）。通訳をご利用の場合は、1-800-479-9502 TTY:711 にご連絡ください。

KOREAN
귀하 본인이나 귀하께서 돕고 계신 분이 CareSource에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 주십시오: 1-800-479-9502 TTY:711.

PENNSYLVANIA DUTCH
Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut CareSource, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-800-479-9502 TTY:711 uffrufe.

RUSSIAN
Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком, позвоните по номеру 1-800-479-9502 TTY:711.

SPANISH
Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-800-479-9502 TTY:711.

UKRAINIAN
Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо CareSource, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, зателефонуйте за номером 1-800-479-9502 TTY:711.

VIETNAMESE
Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về CareSource, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, vui lòng gọi số 1-800-479-9502 TTY:711.

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Notice of Non-Discrimination

CareSource

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please contact CareSource at 1-800-479-9502 TTY:711.

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.