



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 1-855-202-0622. 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 1-855-202-0622 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                              | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$4,900 individual/\$9,800 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> ? | \$6,100 individual/<br>\$12,200 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 1-855-202-0622 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . Services provided by <a href="#">out-of-network providers</a> will not be covered by this <a href="#">plan</a> except in certain limited circumstances (such as emergency care)*. 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> .                                                                                                                                                                                                                                                                                                                                                                        |

\* 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 1-855-202-0622.

 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<br>(You will pay the least)                                 | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                        |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>                                                                                                                                                         | Primary care visit to treat an injury or illness                                    | \$10 copay                                                                   | Not covered                                        | None                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                       | <a href="#">Specialist</a> visit                                                    | \$40 copay                                                                   | Not covered                                        | Plan covers 100% of <u>allowed amount</u> in excess of the <u>copayment</u> . <u>Copayment</u> waived when the only charge is for allergy injections/serum. If you receive services in addition to office visits, additional <u>copayments</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply. |
|                                                                                                                                                                                                                                       | Other practitioner office visit<br>Nurse practitioner/retail clinic<br>Chiropractor | \$10 copay<br>20% coinsurance after deductible                               | Not covered                                        | None<br>Manipulation therapy - 30 visits per benefit year**                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                       | <a href="#">Preventive care/screening/immunization</a>                              | No charge                                                                    | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.                                                                                                                                |
| <b>If you have a test</b>                                                                                                                                                                                                             | <a href="#">Diagnostic test</a> (x-ray, blood work)                                 | X-ray: \$100 copay after deductible<br>Lab: 20% coinsurance after deductible | Not covered                                        | May require prior authorization<br><br>May require prior authorization                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                                                        | \$250 copay after deductible                                                 | Not covered                                        | May require prior authorization                                                                                                                                                                                                                                                                        |
| <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                                                                    | Retail: No charge<br>Mail-Order: No charge                                   | Not covered                                        | Retail: Up to a 30-day supply<br>Mail-Order: Up to a 90-day supply                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                       | Generic drugs                                                                       | Retail: \$15 copay<br>Mail-Order: \$37.50 copay                              | Not covered                                        | Certain drugs may require a prior authorization.                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                       | Preferred brand drugs                                                               | Retail: \$45 copay<br>Mail-Order: \$112.50 copay                             | Not covered                                        | You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.                                                                                                                                                                      |

\* 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 1-855-202-0622.

\*\* 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 Information*                                                                                            |
|-----------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                  | Network Provider<br>(You will pay the least)                                             | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                    |
|                                         | Non-preferred brand drugs                        | Retail: 20% coinsurance after deductible<br>Mail-Order: 20% coinsurance after deductible | Not covered                                        | Retail: Up to a 30-day supply<br>Mail-Order: Up to a 90-day supply                                                                                 |
|                                         | <a href="#">Specialty drugs</a>                  | Retail: 20% coinsurance after deductible<br>Mail-Order: 20% coinsurance after deductible | Not covered                                        | Certain drugs may require a prior authorization.                                                                                                   |
|                                         | <a href="#">Specialty drugs</a> non-preferred    | Retail: 50% coinsurance after deductible<br>Mail-Order: 50% coinsurance after deductible | Not covered                                        | 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)   | 20% coinsurance after deductible                                                         | Not covered                                        | May require prior authorization                                                                                                                    |
|                                         | Physician/surgeon fees                           | 20% coinsurance after deductible                                                         | Not covered                                        | None                                                                                                                                               |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | \$400 copay after deductible                                                             | \$400 copay after deductible                       | <u>Copayment</u> waived if you are admitted to the hospital directly from the Emergency Department.                                                |
|                                         | <a href="#">Emergency medical transportation</a> | 20% coinsurance after deductible                                                         | 20% coinsurance after deductible                   | Ambulance transports must be made to the closest local facility that can provide you with covered services appropriate for your medical condition. |
|                                         | <a href="#">Urgent care</a>                      | \$75 copay                                                                               | \$75 copay                                         | If you receive services in addition to <u>urgent care</u> , additional <u>copayments</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.   |
| If you have a hospital stay             | Facility fee (e.g., hospital room)               | \$400 copay after deductible                                                             | Not covered                                        | Prior authorization required                                                                                                                       |
|                                         | Physician/surgeon fees                           | \$400 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 1-855-202-0622.

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                                               |                                                    | Limitations, Exceptions, & Other Important Information*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|----------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | Network Provider<br>(You will pay the least)                                                    | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$10 copay for office visits and 20% coinsurance after deductible for other outpatient services | Not covered                                        | Prior authorization may be required for all inpatient stays, residential treatment programs, partial hospitalization programs and intensive outpatient services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                  | Inpatient services                        | \$400 copay after deductible                                                                    | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you are pregnant</b>                                                       | Office visits                             | \$40 copay                                                                                      | Not covered                                        | <p><u>Copayment</u> covers initial physician visit and all subsequent prenatal visits, postnatal visits, and physician delivery charges covered under the Global Maternity Fee. Additional <u>copayments</u>, <u>deductibles</u>, or <u>coinsurance</u> may apply depending on services rendered in addition to the Global Maternity Fee.</p> <p>Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u>, or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</p> <p>Your cost for inpatient services only. See above for physician delivery charges.</p> |
|                                                                                  | Childbirth/delivery professional services | \$400 copay after deductible                                                                    | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                  | Childbirth/delivery facility services     | \$400 copay after deductible                                                                    | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 20% coinsurance after deductible                                                                | Not covered                                        | 100 visits per benefit year. A visit equals at least 4 hours.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                  | Chronic pain treatment                    | \$10 copay                                                                                      | Not covered                                        | 20 combined visits per event                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                  | <a href="#">Rehabilitation services</a>   |                                                                                                 | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                  | Physical therapy                          | \$10 copay                                                                                      |                                                    | 30 visits per benefit year**                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                  | Occupational therapy                      | \$10 copay                                                                                      |                                                    | 30 visits per benefit year**                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                  | Speech therapy                            | 20% coinsurance after deductible                                                                |                                                    | 30 visits per benefit year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                  | Cardiac rehabilitation                    | 20% coinsurance after deductible                                                                |                                                    | 36 visits per benefit year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                  | Chiropractic services                     | 20% coinsurance after deductible                                                                |                                                    | Manipulation therapy - 30 visits per benefit year**                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

\* 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 1-855-202-0622.

\*\* 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 Information*                                                                                    |
|----------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                                                                            | Network Provider<br>(You will pay the least)                 | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                            |
|                                        | <u>Habilitation services</u><br>Physical therapy<br>Occupational therapy<br>Speech therapy | \$10 copay<br>\$10 copay<br>20% coinsurance after deductible | Not covered                                        | 30 visits per benefit year**<br>30 visits per benefit year**<br>30 visits per benefit year                                                 |
|                                        | <u>Skilled nursing care</u>                                                                | \$400 copay after deductible                                 | Not covered                                        | Any combination of benefits for skilled nursing facility/inpatient <u>rehabilitation services</u> is limited to 90 days per calendar year. |
|                                        | Private duty nursing                                                                       | 20% coinsurance after deductible                             | Not covered                                        | 35 visits per benefit year. A visit equals 8 hours or less.                                                                                |
|                                        | <u>Durable medical equipment</u>                                                           | 20% coinsurance after deductible                             | Not covered                                        | May require prior authorization                                                                                                            |
|                                        | <u>Hospice services</u>                                                                    | 20% coinsurance after deductible                             | Not covered                                        | Prior authorization is required for inpatient, respite or continuous care levels of care.                                                  |
| If your child needs dental or eye care | Children's eye exam                                                                        | No charge                                                    | Not covered                                        | 1 routine eye exam per benefit year                                                                                                        |
|                                        | Low vision exam                                                                            | 20% coinsurance after deductible                             | Not covered                                        | May require prior authorization                                                                                                            |
|                                        | Children's glasses                                                                         | No charge                                                    | Not covered                                        | Limited to one pair of glasses or a 12-month supply of contact lenses per benefit year                                                     |
|                                        | Children's dental check-up                                                                 | No charge                                                    | Not covered                                        | 2 dental check-ups per benefit year                                                                                                        |

\* 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 1-855-202-0622.

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

### 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                                  |
|                                                                                            | • Long term care   | • 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                                             | • Infertility treatment | • Routine eye care (Adult)                             |
| • Chiropractic care                                             | • Private duty nursing  | • If optional Dental + Vision is selected:             |
| • Dental care (Adult), if optional Dental + Vision is selected: |                         | • \$250 limit per benefit year for glasses or contacts |
| • No charge for preventive services                             |                         |                                                        |
| • 20% coinsurance for basic and major restorative services      |                         |                                                        |
| • \$800 limit per benefit year                                  |                         |                                                        |

**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](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 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 West Virginia Department of Insurance: 1-888-879-9842.

**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 1-855-202-0622.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-202-0622.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-202-0622.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-202-0622.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,900 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$400   |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

#### 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>\$12,840</b> |
|---------------------------|-----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$4,900        |
| Copayments                        | \$545          |
| Coinsurance                       | \$655          |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$6,160</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> | \$4,900 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$400   |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

#### 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>\$7,460</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,489        |
| Copayments                        | \$1,210        |
| Coinsurance                       | \$372          |
| What isn't covered                |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$3,127</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> | \$4,900 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$400   |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

#### 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>\$2,010</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,109        |
| Copayments                        | \$260          |
| Coinsurance                       | \$277          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,646</b> |

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

This Notice has Important Information. This notice has important information about your application or coverage through CareSource. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-855-202-0622 TTY:711.

## ARABIC

يحتوي هذا الإشعار على معلومات مهمة. يحتوي هذا الإشعار على معلومات مهمة. بخصوص طلبك أو التغطية التي تحصل عليها من خلال CareSource. ابحث عن التواريخ المهمة في هذا الإشعار. قد تحتاج إلى اتخاذ إجراء معين قبل حلول أحد التواريخ للحفاظ على التغطية الصحية التي تحصل عليها أو للحصول على مساعدة بشأن التكاليف. يحق لك الحصول على مساعدة ومعلومات مجاناً وباللغة التي تتحدث بها. اتصل على 1-855-202-0622 TTY:711.

**AMHARIC** ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ CareSource ሽፋን አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤናን ሽፋንዎን ለመጠበቅና በአካላዊ እርዳታ ለማግኘት በተወሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ከፍተኛ በጽንዖት እንዲያገኙ መብት አለዎት። 1-855-202-0622 TTY:711 ይደውሉ።

**BURMESE** ဤအသိပေးစာတွင် အရေးကြီးသော အချက်အလက်များ ပါဝင်ပါသည်။ ဤအသိပေးစာတွင် သင့်လျော်ကတားမှု သို့မဟုတ် CareSource အတွင်း အကျိုးဝင်မှုအကြောင်း အရေးကြီးသော အချက်အလက်များ ပါဝင်ပါသည်။ ဤအသိပေးစာတွင် အရေးကြီးသော ရက်စွဲများကို ရှာထားပါ။ သင့်ကျန်းမာရေး အကျိုးဝင်မှုအား ဆက်လက်ထားရှိထားရန် သို့မဟုတ် ကုန်ကျစရိတ်များနှင့် ပတ်သက်ပြီး အကူအညီရရှိရန် အချို့သော နောက်ဆုံးရက် သတ်မှတ်ချက်များဖြင့် ဆောင်ရွက်မှုပြုရန် လိုအပ်နိုင်ပါသည်။ သင့်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ 1-855-202-0622 TTY:711 ဤတွင် နံပါတ်ဖြည့်သွင်းပါ] သို့ ခေါ်ဆိုပါ။

**CHINESE** 此通知包含重要信息。此通知包含关于您的申请以及 CareSource 医疗保险覆盖范围的重要信息。请仔细查看本通知中的关键日期。您可能需要在某些标注的截止日期前采取行动，以确保您的健康保险有效或者付费项目获得帮助。您有权免费获得以您的语言提供的此信息和帮助。请致电 1-855-202-0622 TTY:711。

**CUSHITE – OROMO** Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa CareSource tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhuma irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 1-855-202-0622 TTY:711 tii bilbilaa.

**DUTCH** Deze kennisgeving bevat belangrijke informatie. Deze kennisgeving bevat belangrijke informatie over uw aanvraag of dekking via CareSource. Let op belangrijke data in deze kennisgeving. Het kan nodig zijn om actie te ondernemen vóór bepaalde deadlines om uw gezondheidszorgdekking of hulp met de kosten te behouden. U hebt het recht om deze informatie en hulp kosteloos te ontvangen in uw taal. Bel 1-855-202-0622 TTY:711.

**FRENCH (CANADA)** Cet avis contient des renseignements importants. Cet avis contient des renseignements importants sur votre demande d'assurance auprès de CareSource ou la couverture obtenue par l'intermédiaire de CareSource. Prenez connaissance des dates clés mentionnées dans le présent avis. Assurez-vous de respecter les délais indiqués pour conserver votre protection et contribuer à réduire les coûts. Vous avez le droit d'obtenir gratuitement ces renseignements et du soutien dans votre langue. Téléphonez au 1-855-202-0622 TTY:711.

**GERMAN** Dieser Hinweis enthält wichtige Information. Dieser Hinweis enthält wichtige Information über Ihren Antrag oder Ihren Schutz durch CareSource. Achten Sie auf Schlüsseltermine in diesem Hinweis. Sie müssen eventuell innerhalb von bestimmten Fristen Maßnahmen ergreifen, um Ihre Gesundheitsversorgung aufrecht zu erhalten oder Hilfe mit den Kosten zu bekommen. Sie haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache diese Hilfe und Information zu bekommen. Rufen Sie die Nummer 1-855-202-0622 TTY:711 an.

**GUJARATI** આ સૂચન મં i અગતી મ હલતી છે. આ સૂચન મં i તમ રી અરજ અથિ CareSource દવ રીસાંકળ i ની અગતી મ હલતી છે. આ સૂચન મં i ની ખ સ ત રીખો જ ઓ. તમ તમારા આરોગ્ય કવરેજ રાખવા અથવા ખચે સાથે મદદ કરવો માટે અમક રોકકસ મદતો દવારા પગલા લેવાની જરૂર છે. તમને આ મ હલતી અને મદદ તમ રી ભ પ મ i વિન મૂક મેળિ ની અવિક ર છે. આ 1-855-202-0622 TTY:711 સાંપકય કરો.

**HINDI** इस नोटिस में महत्वपूर्ण सूचना है। इस नोटिस में आपके आवेदन या CareSource के माध्यम से आपके कवरेज के बारे में महत्वपूर्ण जानकारी है। इस नोटिस में मुख्य तारिखों को देखें। आपको लागत सहित अपने हेल्थ कवरेज या सहायता को बनाए रखने के लिए विभिन्न समयसीमाओं में कार्रवाई करने की जरूरत हो सकती है। आपके पास बगैर किसी लागत के अपनी भाषा में यह जानकारी और सहायता प्राप्त करने का अधिकार है। कॉल करें, 1-855-202-0622 TTY:711.

**ITALIAN** Questa comunicazione contiene informazioni importanti. Questa comunicazione contiene informazioni importanti circa la sua iscrizione o copertura tramite CareSource. Cerchi le date principali in questa comunicazione. Potrebbe dover intraprendere delle azioni entro certe scadenze per mantenere la Sua copertura sanitaria o per contribuire ai costi. Ha il diritto di avere queste informazioni e supporto nella Sua lingua, senza alcun costo. Chiami il 1-855-202-0622 TTY:711.

**JAPANESE** この通知には重要な情報が含まれています。この通知には、CareSourceの申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに措置を講じていただく必要があります。ご希望の言語による情報とサポートが無料で提供されます。1-855-202-0622 TTY:711 にご連絡ください。

**KOREAN** 본 통지서는 중요한 정보를 담고 있습니다. CareSource 가입이나 혜택에 대한 중요한 정보가 안내되어 있습니다. 본 통지서에 나와 있는 주요 날짜들을 확인해 주십시오. 의료 혜택을 받거나 비용을 절감하시려면 특정 기한까지 조치를 취하셔야 할 수 있습니다. 원하는 언어로 별도 비용 없이 관련 정보와 안내를 받으실 수 있습니다. 다음 번호로 전화해 주십시오: 1-855-202-0622 TTY:711.

**PENNSYLVANIA DUTCH** Die Bekanntmachung gebt wichdichi Auskunft. Die Bekanntmachung gebt wichdichi Auskunft baut dei Applikation oder Coverage mit CareSource. Geb Acht fer wichdiche Daadem in dei Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmd Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deine eegne Schprooch grieve, un die Hilf koschtet nix. 1-855-202-0622 TTY:711

**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 1-855-202-0622 TTY:711.

**SPANISH** Este aviso incluye información importante. Este aviso incluye información importante sobre su solicitud o su cobertura de CareSource. Busque las fechas clave en este aviso. Es probable que deba realizar acciones dentro de determinado plazo para mantener su cobertura médica o recibir ayuda con los costos. Tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Llame al 1-855-202-0622 TTY:711.

**UKRAINIAN** Це Повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про вашу заяву чи відшкодування через CareSource. Шукайте важливі дати у цьому повідомленні. Вам може знадобитися вжити заходів у певні терміни, щоб отримати медичне страхування чи допомогу з витратами. Ви маєте право на безкоштовне отримання цієї інформації та допомоги вашою мовою. Зателефонуйте за номером 1-855-202-0622 TTY:711.

**VIETNAMESE** Thông báo này có thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin hoặc bảo hiểm của bạn thông qua CareSource. Hãy xem những ngày quan trọng trong thông báo này. Bạn có thể cần phải hành động trước một số thời hạn nhất định để duy trì bảo hiểm sức khỏe của mình hay được trợ giúp có trả phí. Bạn có quyền được nhận thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Vui lòng gọi số 1-855-202-0622 TTY:711.

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 1-855-202-0622 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](mailto: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>.