**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at CareSource.com/marketplace or by calling 1-877-806-9284.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,000 individual/$2,000 family per benefit year. Deductible does not apply to copayments, physician home and office services for primary care, physician home and office services for specialty care, prescription drugs, preventive health services, urgent care services, and vision services – pediatric. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st.) See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. $2,500 Medical/$2,000 Pharmacy individual/$5,000 Medical/$4,000 Pharmacy family | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed 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. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of network providers, see CareSource.com/marketplace or call 1-877-806-9284. | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs for covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| **Do I need a referral to see a specialist?** | No. | You can see the specialist you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about excluded services. |

**Questions:** Call 1-877-806-9284 or visit us at CareSource.com/marketplace.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at CareSource.com/marketplace or call 1-877-806-9284 to request a copy.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $0/visit | Not covered. | No deductible. You only pay the copay. |
| | Specialist visit | $40/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 | 20% coinsurance after deductible | Not covered. | Manipulation therapy - 12 visits per benefit period. |
| | Preventive care/screening/immunization | $0/visit | 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: $75 copay after deductible<br>Lab: 20% coinsurance after deductible | Not covered. | --none-- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Imaging (CT/PET scans, MRIs) | $150/procedure after deductible | Not covered. | Prior authorization required. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at CareSource.com/marketplace | Generic drugs | Retail: $0 copay<br>Mail-Order: $0 copay | Not covered. | Retail: Up to a 31-day supply.<br>Mail-Order: Up to a 90-day supply.<br><br>There is no deductible for prescription drug coverage. You only pay the copayment/coinsurance. |
| | Preferred brand drugs | Retail: $120 copay<br>Mail-Order: $300 copay | Not covered. | Retail: Up to a 31-day supply.<br>Mail-Order: Up to a 90-day supply. |
| | Non-preferred brand drugs | Retail: $160 copay<br>Mail-Order: $400 copay | Not covered. | Retail: Up to a 31-day supply.<br>Mail-Order: Up to a 90-day supply.<br><br>Certain drugs may require a prior authorization.<br><br>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 | Retail: 40% coinsurance<br>Mail-Order: 40% coinsurance | Not covered. | Retail: Up to $300 and up to a 31 day supply.<br>Mail-Order: Up to $300 and up to a 90 day supply. |
| | Specialty drugs non-preferred | Retail: 50% coinsurance<br>Mail-Order: 50% coinsurance | Not covered. | Retail: Up to $300 and up to a 31 day supply.<br>Mail-Order: Up to $300 and up to a 90 day supply. |
| **If you have outpatient** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | Not covered. | Prior authorization required. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **surgery** | Physician/surgeon fees | 20% coinsurance after deductible | Not covered. | --none-- |
| **If you need immediate medical attention** | Emergency room services | $250 copay after deductible | $250 copay after deductible | Copayment waived if you are admitted to the hospital directly from the Emergency Department. |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | --none-- |
| | Urgent care | $75/visit | Not covered. | 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) | $150 per day for days 1-5, $0 per day for days 6-100 | Not covered. | Prior authorization required. |
| | Physician/surgeon fee | 20% coinsurance after deductible | Not covered. | --none-- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/behavioral health outpatient services | $0/visit for office visits and 20% coinsurance after deductible for other outpatient services | Not covered. | Prior authorization required for all inpatient stays, partial hospitalization programs, and intensive outpatient services. |
| | Mental/behavioral health inpatient services | $150 per day for days 1-5, $0 per day for days 6-100 | Not covered. | |
| | Substance use disorder outpatient services | $0/visit for office visits and 20% coinsurance after deductible for other outpatient services | Not covered. | |
| | Substance use disorder inpatient services | $150 per day for days 1-5, $0 per day for days 6-100 | Not covered. | |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you are pregnant** | Prenatal and postnatal care | $40/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. |
| | Delivery and all inpatient services | $150 per day for days 1-5,<br>$0 per day for days 6-100 | 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 | 20% coinsurance after deductible | Not covered. | 100 combined visits per benefit year. |
| | Autism<br>Occupational therapy<br>Speech therapy<br>Behavioral therapy | 20% coinsurance after deductible<br>20% coinsurance after deductible<br>$0/visit | Not covered. | 20 visits per benefit period.<br>20 visits per benefit period. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Rehabilitation services<br>Physical therapy<br>Occupational therapy<br>Speech therapy<br>Cardiac rehabilitation<br>Chiropractic services | 20% coinsurance after deductible<br>20% coinsurance after deductible<br>20% coinsurance after deductible<br>20% coinsurance after deductible<br>20% coinsurance after deductible<br>20% coinsurance after deductible | Not covered. | <br>20 visits per benefit period.<br>20 visits per benefit period.<br>20 visits per benefit period.<br>36 visits per benefit period.<br>Manipulation therapy - 12 visits per benefit period. |
| | Habilitation services<br>Physical therapy<br>Occupational therapy<br>Speech therapy | 20% coinsurance after deductible<br>20% coinsurance after deductible<br>20% coinsurance after deductible | Not covered. | <br>20 visits per benefit period.<br>20 visits per benefit period.<br>20 visits per benefit period. |
| | Skilled nursing care | $100 per day for days 1-5, $0 per day for days 6-100 | Not covered. | Any combination of benefits for skilled nursing facility/inpatient rehabilitation services is limited to 90 days per calendar year. |
| | Private duty nursing | 20% coinsurance after deductible | Not covered. | Limited to 100 visits. |
| | Durable medical equipment | 20% coinsurance after deductible | Not covered. | May require prior authorization. |
| | Hospice service | 20% coinsurance after deductible | Not covered. | Prior authorization required. |
| **If your child needs dental or** | Children's eye exam | $0/visit | Not covered. | Limit of one routine eye exam per benefit year. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **eye care** | Low vision exam | 20% coinsurance after deductible | Not covered. | 1 exam and follow-up visit every 5 years. |
| | Children's eye wear | 20% coinsurance after deductible | Not covered. | Limited to 1 pair per benefit year and 1 replacement pair if medically necessary. |
| | Children's dental | $0/visit for preventive<br>25% coinsurance for major restorative services<br>20% coinsurance for orthodontic services | Not covered. | 2 dental check-ups per benefit period.<br>Orthodontia lifetime limit $3,000. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

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

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Dental care (Adult), if optional Dental + Vision is selected:
  - $0 copay preventive and basic services
  - 25% coinsurance for major restorative services
  - $800 annual maximum
- Private duty nursing
- Routine eye care (Adult), if optional Dental + Vision is selected:
  - $25 copay
  - $150 annual maximum

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to continue health coverage after it would otherwise end. For more information, contact us at 1-877-806-9284 or contact 1-317-232-2385. Other options to continue coverage are 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:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, contact the Indiana Department of Insurance: 1-317-232-2385.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-877-806-9284.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-806-9284.]

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-806-9284.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-806-9284.]

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

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,040
- **Patient pays:** $1,500

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,000 |
| Copays | $270 |
| Coinsurance | $80 |
| Limits or exclusions | $150 |
| **Total** | $1,500 |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,100
- **Patient pays:** $1,300

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,000 |
| Copays | $0 |
| Coinsurance | $220 |
| Limits or exclusions | $80 |
| **Total** | $1,300 |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-877-806-9284 or visit us at CareSource.com/marketplace.
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