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?	$5,300 individual/$10,600 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?	$6,750 individual/ $13,500 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	50% coinsurance after deductible	Not covered	None
	Specialist visit	50% coinsurance after deductible	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	50% coinsurance after deductible 50% coinsurance after deductible	Not covered	None 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: 50% coinsurance after deductible Lab: 50% coinsurance after deductible	Not covered	May require prior authorization May require prior authorization
	Imaging (CT/PET scans, MRIs)	50% coinsurance after deductible	Not covered	Prior authorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caresouce.com/ marketplace.	Preventive drugs	Retail: No charge Mail-Order: No charge	Not covered	Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply for Preventive, Low Cost, and Brand drugs/Up to a 30-day supply for Specialty drugs Certain drugs may require a prior authorization.
	Low cost drugs	Retail: 50% coinsurance after deductible Mail-Order: 50% coinsurance after deductible	Not covered	

* 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)	
	Preferred brand drugs	Retail: 50% coinsurance after deductible Mail-Order: 50% coinsurance after deductible	Not covered	Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply for Preventive, Low Cost, and Brand drugs/Up to a 30-day supply for Specialty drugs Certain drugs may require a prior authorization.
	Non-preferred brand drugs	Retail: 50% coinsurance after deductible Mail-Order: 50% coinsurance after deductible	Not covered	
	Specialty drugs preferred	Retail: 50% coinsurance after deductible Mail-Order: 50% coinsurance after deductible	Not covered	
	Specialty drugs non-preferred	Retail: 50% coinsurance after deductible Mail-Order: 50% coinsurance after deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance after deductible	Not covered	May require prior authorization
	Physician/surgeon fees	50% coinsurance after deductible	Not covered	May require prior authorization
If you need immediate medical attention	Emergency room care	50% coinsurance after deductible	50% coinsurance after deductible	Copayment waived if you are admitted to the hospital directly from the Emergency Department.
	Emergency medical transportation	50% coinsurance after deductible	50% coinsurance after deductible	Prior authorization is not required for emergency ambulance transportation or for facility to facility transfers. All other ambulance transportation requires prior authorization.
	Urgent care	50% coinsurance after deductible	50% coinsurance after deductible	If you receive services in addition to urgent care, additional copayments, deductibles, or coinsurance may apply.

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 have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance after deductible	Not covered	Prior authorization required
	Physician/surgeon fees	50% coinsurance after deductible	Not covered	Prior authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% coinsurance after deductible for office visits and 50% coinsurance after deductible for other outpatient services	Not covered	Prior authorization is required for all inpatient stays and residential treatment programs. Partial hospitalization programs and intensive outpatient services may require prior authorization.
	Inpatient services	50% coinsurance after deductible	Not covered	
If you are pregnant	Office visits	50% coinsurance after deductible	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	50% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	50% coinsurance after deductible	Not covered	Your cost for inpatient services only. See above for physician delivery charges.

* 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)	
If you need help recovering or have other special health needs	Home health care	50% coinsurance after deductible	Not covered	Prior authorization required 100 combined visits per benefit year. A visit equals at least 4 hours.
	Autism Physical therapy Occupational therapy Speech therapy Behavioral therapy	 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible	Not covered	 20 visits per benefit year 20 visits per benefit year 20 visits per benefit year None
	Rehabilitation services Physical therapy Occupational therapy Speech therapy Cardiac rehabilitation Pulmonary rehabilitation Chiropractic services	 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible	Not covered	 20 visits per benefit year 20 visits per benefit year 20 visits per benefit year 36 visits per benefit year 20 visits per benefit year Manipulation therapy - 12 visits per benefit year
	Habilitation services Physical therapy Occupational therapy Speech therapy	 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible	Not covered	 20 visits per benefit year 20 visits per benefit year 20 visits per benefit year
	Skilled nursing care	50% coinsurance after deductible	Not covered	Prior authorization required 90 day limit 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)	
	Private duty nursing	50% coinsurance after deductible	Not covered	Prior authorization required 100 visits per benefit year. A visit equals 8 hours.
	Durable medical equipment	50% coinsurance after deductible	Not covered	May require prior authorization
	Hospice services	50% 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	50% coinsurance after deductible	Not covered	1 routine eye exam per benefit year
	Low vision testing and aids	No charge	Not covered	Limited to one evaluation and aid per benefit year.
	Children's eyewear	50% coinsurance after deductible	Not covered	Limited to one pair of glasses or contact lenses once per benefit year. If medically necessary, a replacement pair of glasses is allowed.
	Children's dental check-up	50% coinsurance after deductible	Not covered	2 dental check-ups per benefit year

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
- Dental care (Adult)
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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
- Infertility treatment
- Private duty nursing

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

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	$5,300
Specialist *coinsurance*	50%
Hospital (facility) *coinsurance*	50%
Other *coinsurance*	50%

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	$1,720
Copayments	$0
Coinsurance	$5,030
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,810**

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

The plan's overall deductible	$5,300
Specialist *coinsurance*	50%
Hospital (facility) *coinsurance*	50%
Other *coinsurance*	50%

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	$3,350
Copayments	$0
Coinsurance	$3,400
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$6,805**

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

The plan's overall deductible	$5,300
Specialist *coinsurance*	50%
Hospital (facility) *coinsurance*	50%
Other *coinsurance*	50%

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	$963
Copayments	$0
Coinsurance	$963
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,926**

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