



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 844-539-1733. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary).

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | \$4,500 individual/\$9,000 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> . |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | 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.  |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No   | You don't have to meet <a href="#">deductibles</a> for specific services.  |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | \$8,200 individual/\$16,400 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.  |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <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> .  |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://www.caresource.com/marketplace">www.caresource.com/marketplace</a> or call 844-539-1733 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ).*  |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | No   | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .   |

\*Balance billing does not apply in West Virginia.  
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| Common Medical Event   | Services You May Need                                   | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Network Provider 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 provider's office or clinic</b>  | Zero cost telehealth partner                            | No charge                                    | Not covered  | Refer to your Evidence of Coverage   |
|  | Primary care visit to treat an injury or illness.       | \$30 copay                                   | Not covered  | None   |
|  | <a href="#">Specialist</a> visit                        | \$70 copay                                   | Not covered  | None   |
|  | <a href="#">Preventive care/screening</a> /immunization | No charge                                    | Not covered  | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.  |
| <b>If you have a test†</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)     | X-ray: \$200 copay after deductible          | Not covered  | None   |
|  |   | Lab: \$50 copay                              |  | None   |
|  | Imaging (CT/PET scans, MRIs)                            | \$250 copay after deductible                 | Not covered  | None   |
| <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  | No charge                                    | Not covered  | Up to a 90-day supply when filled at: Retail or Mail Order for drugs in Tiers 0-3<br>All others limited to a 30-day supply<br>Any copays shown are for a 30-day supply. 90-day supplies are 3 times the copay. Insulin cost share not to exceed \$35 per 30-day supply in aggregate. |
|  | Generic drugs   | Up to \$3 copay                              | Not covered  |  |
|  | Preferred brand drugs                                   | Up to \$70 copay                             | Not covered  |  |
|  | Non-preferred brand drugs                               | 40% coinsurance after deductible             | Not covered  |  |
|  | <a href="#">Specialty drugs</a>                         | 50% coinsurance after deductible             | Not covered  |  |
| <b>If you have outpatient surgery†</b>   | Facility fee (e.g., ambulatory surgery center)          | 40% coinsurance after deductible             | Not covered  | None   |
|  | Physician/surgeon fees                                  | 40% coinsurance after deductible             | Not covered  | None   |
| <b>If you need immediate medical attention</b>   | <a href="#">Emergency room care</a>                     | \$500 copay after deductible                 | \$500 copay after deductible                       | Emergency room copay or coinsurance is waived if you are admitted to the hospital directly from the Emergency Department.  |
|  | <a href="#">Emergency medical transportation</a>        | 40% coinsurance after deductible             | 40% coinsurance after deductible                   | 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 844-539-1733.

†Prior authorization may be required, for more details see [www.caresource.com/mp-WV-pa](http://www.caresource.com/mp-WV-pa).

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

| Common Medical Event  | Services You May Need                      | What You Will Pay   |  | Limitations, Exceptions, & Other Important Network Provider Information*  |
|---|--|---|--|---|
|   |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
|   | <a href="#">Urgent care</a>                | \$60 copay  | \$60 copay   | If you receive services in addition to <a href="#">urgent care</a> , additional <a href="#">copayments</a> , <a href="#">deductibles</a> , or <a href="#">coinsurance</a> may apply.  |
| <b>If you have a hospital stay†</b>   | Facility fee (e.g., hospital room)         | 40% coinsurance after deductible  | Not covered  | None  |
|   | Physician/surgeon fees                     | 40% coinsurance after deductible  | Not covered  | 1 visit per physician per day   |
| <b>If you need mental health, behavioral health, or substance abuse services†</b> | Outpatient services                        | \$30 copay for office visits and 40% coinsurance after deductible for other outpatient services | Not covered  | None  |
|   | Inpatient services                         | 40% coinsurance after deductible  | Not covered  | None  |
| <b>If you are pregnant</b>  | Office visits                              | \$70 copay  | Not covered  | Cost sharing does not apply for preventive services. Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|   | Childbirth/delivery professional services† | 40% coinsurance after deductible  | Not covered  |   |
|   | Childbirth/delivery facility services†     | 40% coinsurance after deductible  | Not covered  | Your cost for inpatient services only. See above for physician delivery charges.  |

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| Common Medical Event  | Services You May Need                      | What You Will Pay                            |   | Limitations, Exceptions, & Other Important Network Provider Information*   |
|---|--|--|---|--|
|   |  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most)            |  |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a> †         | 40% coinsurance after deductible             | Not covered   | Private-Duty Nursing limited to 35 visits per Benefit Year. 100 visits per Benefit Year for other services. Refer to your Evidence of Coverage for additional information.   |
|   | <a href="#">Rehabilitation services</a> †  |  |   |  |
|   | Physical/Occupational therapy              | \$30 copay                                   | Not covered   | PT**, OT**, Manipulation therapy**, Pulmonary limited to 30 visits each per Benefit Year. Cardiac limited to 36 visits.  |
|   | Speech/Post-cochlear implant aural therapy | \$30 copay                                   | Not covered   |  |
|   | All other services                         | 40% coinsurance after deductible             | Not covered   |  |
|   | <a href="#">Habilitation services</a> †    |  |   |  |
|   | Physical/Occupational therapy              | \$30 copay                                   | Not covered   | 30 visits per Benefit Year   |
|   | Speech therapy                             | \$30 copay                                   | Not covered   | None   |
| Manipulation therapy  | 40% coinsurance after deductible           | Not covered                                  | Manipulation therapy** limited to 30 visits per Benefit Year. |  |
| Chronic pain treatment  | 40% coinsurance after deductible           | Not covered                                  | 20 combined visits per event                                  |  |
| <a href="#">Skilled nursing care</a> †                                | \$500 copay after deductible per stay      | Not covered                                  | None  |  |
| <a href="#">Durable medical equipment</a> †                           | 40% coinsurance after deductible           | Not covered                                  | Refer to your Evidence of Coverage                            |  |
| <a href="#">Hospice services</a>                                      | 40% coinsurance after deductible           | Not covered                                  | Refer to your Evidence of Coverage                            |  |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                        | No charge                                    | Not covered   | 1 routine eye exam per Benefit Year  |
|   | Children's eyewear                         | No charge                                    | Not covered   | Limited to one pair of glasses or contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed. Refer to your Evidence of Coverage for additional eyewear options that may have an additional charge. |

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

| Common Medical Event | Services You May Need      | What You Will Pay                         |   | Limitations, Exceptions, & Other Important Network Provider Information* |
|----------------------|----------------------------|---|---|--|
|                      |                            | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) |  |
|                      | Children's dental check-up | Not covered                               | Not covered                                     |  |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>Acupuncture</li> <li>Cosmetic surgery</li> </ul>         | <ul style="list-style-type: none"> <li>Dental care</li> <li>Hearing aids</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Chiropractic care</li> </ul>   | <ul style="list-style-type: none"> <li>Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>Private-duty nursing</li> </ul> |

**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 on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: West Virginia Department of Insurance: 1-888-879-9842.

### Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet the Minimum Value Standards? Not Applicable

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 844-539-1733

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-539-1733

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-539-1733

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 844-539-1733.

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You may view the Access Plan required by Health Benefit Plan Network Access and Adequacy Act online at [CareSource.com]. You may also contact us at 1-833-230-2099 to request a copy.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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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](#) \$4,500
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 40%
- coinsurance after deductible
- Other [coinsurance](#) 40%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$4,500        |
| <a href="#">Copayments</a>        | \$80           |
| <a href="#">Coinsurance</a>       | \$1,700        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$6,280</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$4,500
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 40%
- coinsurance after deductible
- Other [coinsurance](#) 40%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$200          |
| <a href="#">Copayments</a>        | \$2,000        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$2,200</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$4,500
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 40%
- coinsurance after deductible
- Other [coinsurance](#) 40%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,300        |
| <a href="#">Copayments</a>        | \$100          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,400</b> |

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